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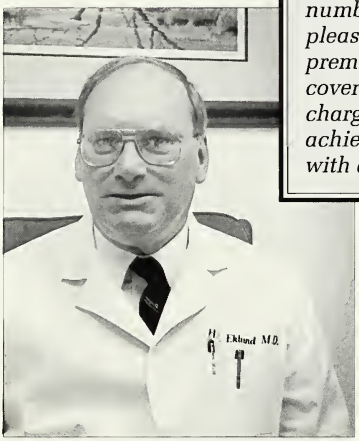
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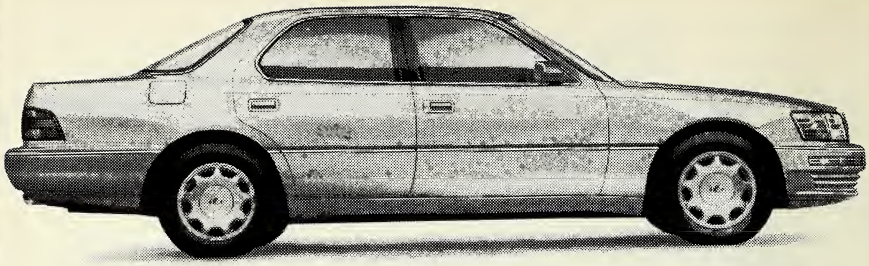
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Joe Battles, Indianola, took this picture in Colorado's Rocky Mountain National Park. Mr. Battles works for U.S. West and does commercial photography work in his Indianola studio, Battles Photography.

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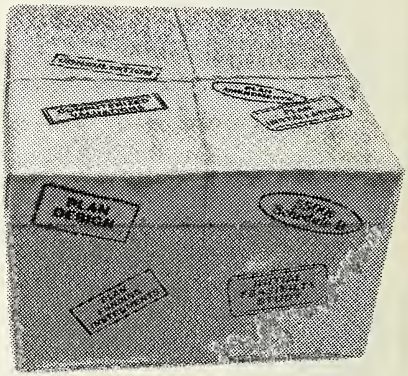
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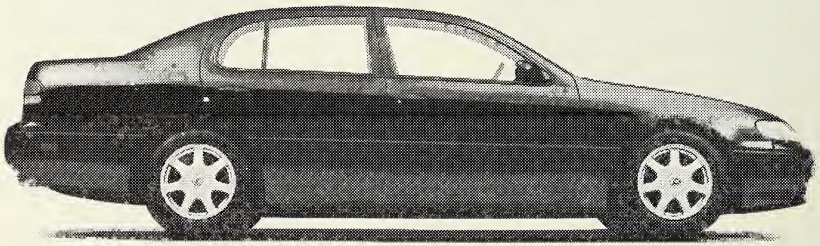
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eve O'Brien, Boone, shot this photo entitled *Window Reflections* in LaCrosse, Wisconsin. ir. O'Brien is an industrial photographer and raphic specialist for Little Giant Crane and hovel, Inc., Des Moines. He also maintains a arkroom in his Boone home.

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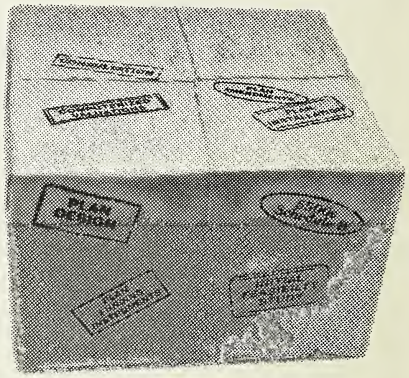
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The first significant advance in treatment of schizophrenia.
Robert Smith, M.D.; Mary Sukowatey, R.N.; Kathy Solko, A.C.S.W.; Joan Christensen, A.C.S.W.; Juliann Saak, R.N.; Anne Burnham, M.S.W.

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St. Luke's Regional Heart Center

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A Symposium for Physicians

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Intended Audience:

Cardiologists, internists, and family practitioners who deal with cardiovascular disorders.

Symposium Description:

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Accreditation:

CME: St. Luke's Hospital is accredited by the Iowa Medical Society to sponsor continuing medical education for physicians. St. Luke's Hospital designates this CME offering meets the criteria for 6.5 hours in Category I of the AMA Physician's Recognition Award.

AAFP: This program has been reviewed and is acceptable for 6.5 prescribed hours by the American Academy of Family Physicians.

Registration Information:

Registration Fee: $95 includes attendance at the symposium, two free tickets for the Friends of Bix' Cocktail Party, 2 complimentary tickets for the Riverboat Gambling Cruise and 2 entries in the Bix 7 Road Race.

Registration Deadline: July 1, 1993. Confirmation and details about entertainment options will be sent upon registration. Please direct any concerns to Rebecca Gannon(319) 326-8115. Refund policy: A refund less a $25.00 processing fee if your request is postmarked by July 15, 1993.

Morning Schedule

8:00- 8:20 Registration-Continental Breakfast

8:20- 8:35 Welcome - Symposium Overview - Dr. Giudici

8:35- 9:15 "Lipid Disorders" Dr. Connor

9:15- 9:55 "Advances in the Treatment of Atrial Fibrillation/Flutter" Dr. Waldo

9:55-10:20 Break

10:20-11:00 "Renal Implications and the Treatment of Essential Hypertension" Dr. Gratch

11:00-11:40 Panel

11:40-12:55 Lunch with the Speakers

Afternoon Schedule

12:55- 1:35 "Management of Ventricular Arrhythmias" Dr. Wilber

1:35- 2:15 "New Techniques in Interventional Cardiology" Dr. Fischman

2:15- 2:35 Break

2:35- 3:15 "Non-Invasive Cardiology Update" Dr. Miller

3:15- 3:55 Panel

St Luke's Hospital

St. Luke's Regional Heart Center • 1227 East Rusholme Street • Davenport, Iowa 52803

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10TH ANNUAL

PROGRESS IN INTERNAL MEDICINE

October 14-15, 1993

TOPICS

- New insights into hypertension and diabetes
- Mandated care guidelines: dementia and incontinence
- Pneumonia in Iowa
- Curent approaches to the management of migraine headache
- Hereditary angiodema
- Management of BPH: the role of the primary physician
- What is a free radical?
- Office approach to common anorectal diseases
- Atrial fibrillation: current therapy
- Spouse abuse: the misdiagnosis
- Organ transplant: where we are, where we are going

WORKSHOPS

- Therapeutics Update: Antibiotics
- The Female Genital (Pelvic) Exam
- The Male Genital/Rectal Exam
- Common Thyroid Problems: Interactive Case Presentations
- The Future of Medical Information Transferra

SPECIAL EVENTS

Big 10 Football, Saturday, October 16: Iowa vs. Illinois. Limited number of tickets available to course participants.

REGISTRATION

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Dr. Everett Nitzke, a Des Moines pediatrician, took this photograph in Big Bend National Park in southwest Texas.

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President's Privilege



William Eversmann, Jr., M.D.

Roundtable discussion

THE ARENA OF HEALTH care reform has convened a heterogeneous group of insurance executives, businessmen, hospital administrators, physicians, public policy administrators and other interest groups.

Through the Iowa Leadership Consortium (ILC) these diverse groups agreed that health care reform should be based on the premise that the uninsured and underinsured should have access to care, that the quality of health care should be preserved and that the rising cost of delivering health care should be controlled. The principles of maintenance of quality, increase in access and control of cost were established and the discussion of methods to achieve these goals began.

For the past two years, the discussions have continued. Presently it appears to this participant-observer that quality is desirable and preservable particularly when associated with cost reduction. If a dramatic increase in quality could be achieved with increased cost, a detailed statistical justification, research projects, data collections and practice parameters would be required to assure that the increased quality was desirable.

In a more recent unofficial discussion among ILC members, the question was raised "why does business have to pay for the uninsured?" Fortunately the medical profession has continued, as we should, to treat the uninsured, usually without compensation and without the benefit of cost shifting. However, it appears that not everyone at the table of discussion is so dedicated.

The principles of health care reform for the medical profession have not changed from access, quality and cost to cost, cost, cost.

The brighter side of health care reform is that Iowa physicians continue to participate at the table of discussion and have as yet not been the main course.

1 9 9 3



5TH ANNUAL CEDAR RAPIDS HEART SYMPOSIUM

FOR THE PRACTICING PRIMARY CARE PHYSICIAN

February 26, 1993
COLLINS PLAZA HOTEL
CEDAR RAPIDS, IOWA

Keynote Speakers
Greg C. Flaker, M.D.
Michael D. Winniford, M.D.

Keynote Speakers
Ronald M. Lauer
Robert L. Replogle

Course Objectives and Intended Audience

This course is designed to provide family practitioners, internists, other primary care physicians and nurses with practical approaches to common cardiovascular disorders. The course will emphasize diagnostic evaluation, treatment modalities and day-to-day management of these disorders from the perspective of the primary care physician.

Accreditation

Credit hours have been applied for through the following organizations:

American Academy of Family Physicians
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CME's by Cedar Rapids Medical Education Program
CEU's by Mercy Medical Center

Registration Fees:

Physicians $50.00
Nurses and Residents $25.00
(includes course materials, breakfast, lunch and refreshments)

Registration Deadline is February 18, 1993.
Registration is limited. For registration information, please contact June Zenisek, R.N., Symposium Coordinator, 319-362-5118 or 1-800-728-5118.

Agenda

8:30	Registration
9:00	Opening Remarks—Dr. Ersin Atay
9:15	Atrial Fibrillation: New Ideas on an Old Arrhythmia Dr. Greg Flaker
10:00	Interventional Cardiology in the 90's— Dr. Michael Winniford
10:45	Break
11:00	Healthcare in the 90's: Cost versus Technology— Dr. Robert L. Replogle
11:45	Question Session
12:15	Lunch
1:15	The Significance of Cholesterol in Childhood— Dr. Ronald M. Lauer
2:00	Break

Concurrent Workshops

2:15	—Mitral Valve Prolapse—Dr. Todd Langager —Peripheral Vascular Disease—Dr. Kevin Kope —Rehabilitation of the Cardiac Patient— Dr. David Rater
3:00	Break
3:15	—Echocardiograms in Congenital Heart Disease Dr. Stephen Roth —Innocent Heart Murmurs—Dr. Ronald Lauer —Medical Case Studies—Dr. Richard Fleming
4:00	Evaluations

The Editor Comments



Marion E. Alberts, M.D.

Children aren't second-class citizens

MOST ACCOUNTS WE READ about long-term care of ill and disabled persons focus on the adults. But, what of the many children who require long-term care, oftimes for their entire life span? Children are not second-class citizens. Most communities do not have long-term care facilities for children. Certainly, the existing long-term care facilities designed for adults are hardly the environment for the care of children.

True, many children with long-term disabilities can be cared for in their home, but there is a limit to the services and equipment adaptable to home use. The developing children require an approach to their disabilities which is different than that for an adult. The entire setting must be appropriate for the mind-set of the child. Education beyond the adaptations necessary for the disability are required, for the child must continue to receive basic education within individual capabilities.

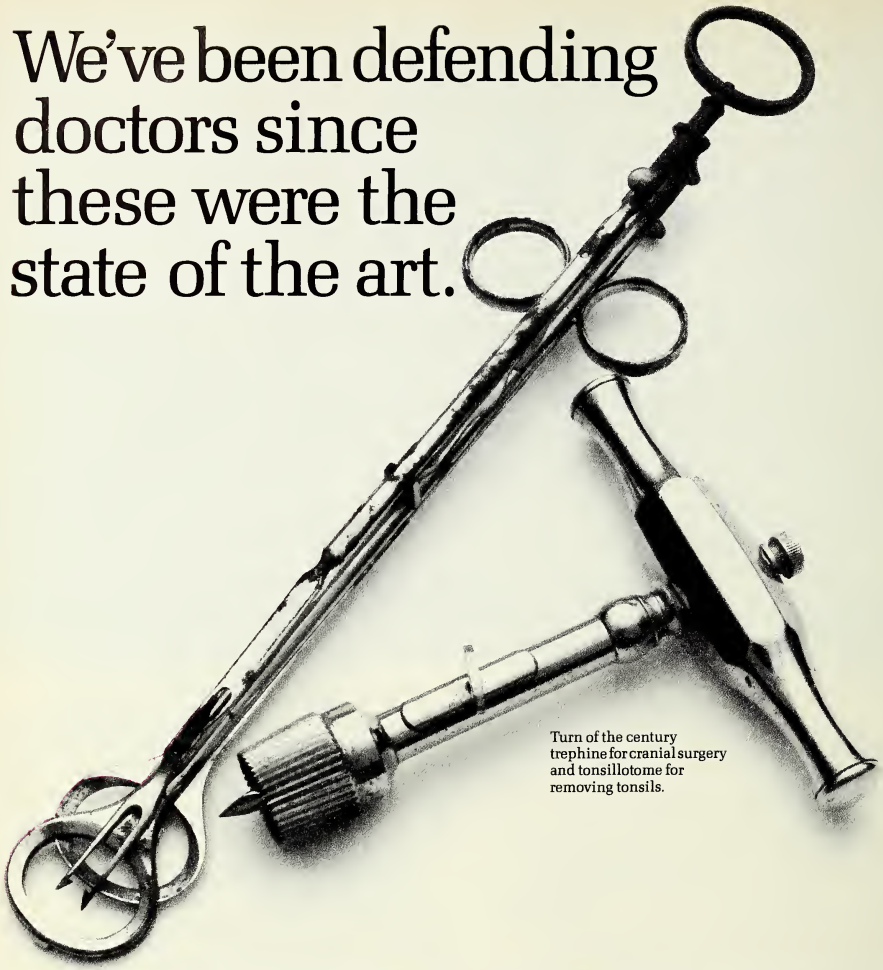
Psychological impacts upon the disabled child are different than that of the adult. The adult may be greatly concerned with self-help, as well as concerns for family members and the implications of employment. The child may not have these concerns, but certainly has concerns about self-worth, future abilities, further education and peer relationships. Specialized equipment must be adaptable to the child's size. The provisions of care must be in the hands of persons trained to deal with children rather than being adult oriented. In addition, the family of the disabled child must develop an understanding of the total picture and be taught to deal with it.

Long-term care for an adult may be measured in months to a few years in many instances. For children the time span may be extended . . . from infancy to adulthood. The needs for specialized facilities and the economics are of no small concern. Herein arises the spector of the source of funds for such care . . . private insurance as well as governmental assistance.

Often, governmental assistance is based on care within a hospital setting; the assistance ceasing when the child is cared for in the home. Several landmark cases have been reported where presidential intervention has circumvented bureaucratic guidelines and seemingly non-compromising edicts. More concern must be given by the lawmakers to such problems.

To reiterate: children are not second-class citizens. They frequently require long-term care. Provisions through private as well as governmental agencies must provide for these unfortunate children. Let us not be blinded by the well-meaning groups who have the interests of adults foremost in their plans. Give the children an equal opportunity to have a life that has quality, love, compassion and concern from all quarters.

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Caring for the elderly: a crisis on the horizon

As baby boomers age, the proportion of elderly people will increase. Growing numbers of senior citizens coupled with shrinking budgets may force society to find alternatives to nursing homes, predicts a Des Moines geriatrician.

Yesterday, a woman who was my neighbor brought an 86-year-old man to my office. She said she was his 'good friend' of many years. Maybe she was his girlfriend once, long ago. He was very confused and she had been trying to help him . . . fixing his meals, even calling him when it was time to take his medication. Elderly people deteriorate so gradually that not even their families realize how much the neighbor is doing. No one realizes until the neighbor—like this lady—gets what we call 'caretaker fatigue.' That's when they show up in my office.

—Roy Overton, II, M.D.

UNLESS ALTERNATIVES TO nursing homes are developed, we will face a burgeoning crisis in long-term care as baby boomers age, predicts Des Moines geriatrician Dr. Roy Overton, II.

Dr. Overton, who has a thriving geriatrics practice, says there is already a shortage of physicians in his specialty. The situation is bound to get worse as the percentage of elderly people grows and the Medicaid budget shrinks.

"Consider the person who has saved all their life for their old age. They go into a nursing home as a private pay patient and their money lasts an average of 13 weeks. Even the cheaper nursing homes are $55 a day," relates Dr. Overton.

So what will be the solution to this growing problem in the future?

"Before too long, 15-20% of our population will be geriatric. We're going to have to face the fact that more people will be staying in their homes instead of going into long-term care facilities," he says.

More physicians need more education on caring for elderly people, Dr. Overton believes.

"Geriatric medicine is different, and we need more CME programs in geriatrics. There's a difference between normal aging and pathological aging," he explains. "Some people aren't just old, they're sick. Their symptoms aren't a part of the aging process."

When a physician is faced with a patient such as the one Dr. Overton described in the opening scenario, it is vitally important to do a complete geriatric evaluation before determining what should be done.

"Often, these situations may seem to be an emergency, but actually the problem developed very gradually. Usually, caretaker fatigue is the reason the patient is brought to the doctor."

(Continued next page)

Dr. Overton is vice president of the Iowa Association of Long-Term Care Facility Medical Directors.

To make a determination about what should be done, Dr. Overton does a "mini-mental health status" test which shows if the patient can tell time, if they know where they are and if they can reason. He checks for bruises and scrapes and he asks about the patient's lifestyle. He also tries to find out what family members are willing to do.

'Sometimes, the only way to find out about their lifestyle is to make a house call. It doesn't hurt a physician to do that.'

"We can keep lots of people in their homes if the families are willing to help out. I have one elderly lady who has about 20 relatives who all take turns going to her house," he relates. "The most important things a doctor can do are to ask questions and observe. If a patient says 'I don't feel good,' it may really mean 'Help me,' " he comments.

The amount of money a patient has also can help physicians make a decision on appropriate caretakers.

"There are services available to patients who can pay, such as temporary total care for elderly people whose family members are out of town," Dr. Overton relates. "The Medic Alert system has allowed a tremendous number of people to stay in their homes, but there is an extensive waiting list."

Despite complete geriatric evaluations, deciding whether a patient can remain at home is "almost always a judgment call," Dr. Overton admits. Patients with progressive disease, patients who wander, patients who have no family and patients who cannot take medications correctly are obvious candidates for intermediate care facilities, he explains. However, he says urinary or fecal incontinence are common reasons why elderly people are sent to nursing homes.

"Elderly people who are endangering themselves must go to a care facility," he says. "Sometimes, the only way to find out about their lifestyle is to make a house call. It doesn't hurt a physician to do that."

New OBRA regulations requiring physicians to visit patients more often in intermediate care facilities have been "harder on physicians here because Iowa has a high percentage of these facilities," Dr. Overton says.

"Of course, some of these regulations came about because some doctors didn't do their jobs," he comments. "Now, because of restrictive regulations physicians are losing the opportunity to individualize for their patients."

Contrary to popular belief, the nursing home situation is "not just an urban problem," Dr. Overton insists.

"Older people from small towns follow their children to the nursing home in the city. Consequently, many of the elderly people in facilities in Des Moines are actually from rural Iowa. Sometimes those elderly people would be better off if they stayed in the small towns where their friends are. Of course, I have some patients who have outlived everyone—their children, most of their family and all their friends. I'm their only visitor."

There are many services available to help elderly people, relates Dr. Overton. He advises physicians to contact their county nurse or the social worker in their local hospital for information about services they may not be aware of. Physicians with elderly patients should also watch their local paper for notices about free clinics and medical services available to senior citizens.

'Geriatric medicine is different, and we need more CME programs in geriatrics. There's a difference between normal aging and pathological aging.'

There is a growing realization, says Dr. Overton, that it is financially and psychologically undesirable to put so many people in nursing homes. He believes families will have to assume more responsibility in the care of aging relatives and that more programs will focus on using Medicaid money to keep people in their homes rather than in a care facility. (See sidebar story.)

"The goal is for these patients to be as autonomous as possible, making their own decisions, mobile and free from pain," he concludes.

New Medicaid program promotes caring for elderly at home

A NEW STATE PROGRAM offers a welcome alternative to nursing homes by promoting caring for elderly people in their homes. Under a waiver granted by the Health Care Financing Administration, the "Medicaid Home and Community Based Services Waiver Program for the Elderly" is available in the following counties: Cerro Gordo, Decatur, Fayette, Keokuk, Linn, Ringgold, Scott, Black Hawk, Howard, Dubuque, Johnson, Hamilton, Polk and Muscatine. Under the program, Medicaid will pay for selected home based services, including:

- Adult day services—Services provided in day care setting for elderly persons who need supervision and assistance.
- Emergency response systems—An electronic monitoring system placed in the home of an elderly person which will alert medical personnel in case of an emergency.
- Home health services—Personal assistance and home health services not normally covered under a state Medicaid program, including assistance with bathing, dressing and a variety of other daily activities.
- Respite care service—Temporary care provided in a facility or the client's home to provide relief for the care giver.
- Nursing care services—Services provided by licensed agency nurses to clients in the home. Nursing care services must be reasonable and necessary to the treatment of an illness or injury and included in a plan of treatment established by a physician.
- Homemaker services—Assistance with cleaning, meal preparation, shopping and other duties the client is unable to do for themselves.

To be eligible for the waiver program, the person must be 65 years old or older, a resident of one of the 15 counties already listed and eligible for Medicaid or meet eligibility guidelines for a person in a medical institution (income, resources).

Other criteria include:

- The person must be certified as being in need of care in an intermediate care facility or a skilled nursing facility, and must currently reside outside of a medical institution or nursing facility.
- The person must receive case management services from the Case Management Project for the Frail Elderly (CMPFE).
- The total monthly cost of the elderly waiver services cannot exceed the cost of the recipient's care if it were provided by a skilled nursing facility or an intermediate care facility.

The program is limited to 200 persons at any one time; currently there are fewer than 30 participants.

If physicians in the listed counties are aware of someone who might be eligible for the program, the person may apply at the local Department of Human Services Office or the Case Management Program for the Frail and Elderly of the local Area Agency on Aging. The application process takes aproximately one month for someone who is eligible for Medicaid. The approval process is longer for those who must prove Medicaid eligibility. Financial participation by the client may be necessary based upon ability to pay.

Physicians with questions about the program should call Mary Cogley in the Division of Medical Services of the Iowa Department of Human Services at 515/281-3002.

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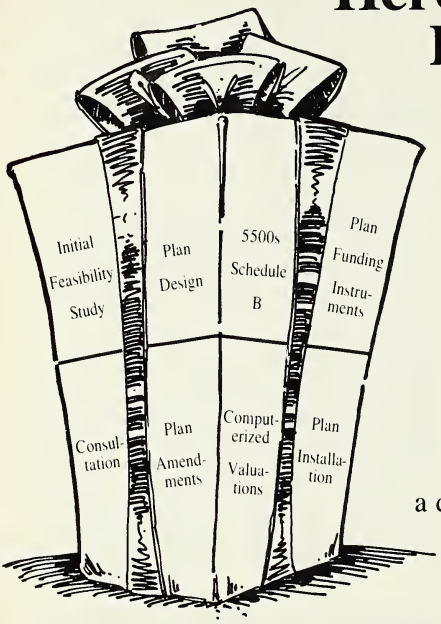
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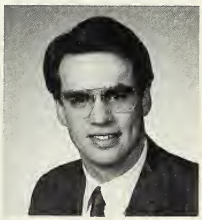
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Advice to transplant patients? Ask questions

Organ transplantation has meant a miraculous prolongation of life for many Iowans. However, this young man's story—sent unsolicited to the editors of IOWA MEDICINE—illustrates what happens when a patient has unrealistic expectations of what life will be like after a transplant.

Brad Lofton
Bloomfield, Iowa

IN 1987 I RECEIVED A double transplant, a kidney and a pancreas. Technically, I'm doing fine. However, if I could turn back the clock I would not go through it again.

Unlike many other transplant patients, my problems didn't appear within a relatively short period of time. I had lived with diabetes since my early teens; when I reached my twenties many other things attributed to diabetes started going wrong.

First, poor circulation left my feet cold and numb. Then nerve deterioration caused me to lose normal feeling in my feet. Several times I injured my feet and, because I didn't feel pain, my injuries went unnoticed until infection set in. Next, I developed diabetic retinopathy, a disease which causes new veins to form in the eye. Because these veins are poorly formed, they can burst and cause blindness. As these things occurred my body weakened and my ability to work suffered. Each time I experienced a problem I was forced to take a lesser job at less pay.

As I reached 30, I couldn't walk more than a few yards and sometimes required a cane. My kidneys quit and I had to be put on dialysis, two and then three times weekly. That was an experience I will never go through again. I weighed 132 pounds after the excess fluids were removed from my system. Each day I required two naps, each two hours long, besides a normal nights' sleep.

I had been interested in a pancreas transplant for some time but they were still experimental. After my kidneys failed, the possibility of a transplant became greater as a body is more accepting of foreign organs when it is twice weakened. I underwent numerous tests for tissue typing and to see if my heart could take the strain of being on the operating table the necessary number of hours. My parents had helped me pay my health insurance all the years of my illness, so the pancreas transplant was covered. However, it had to be applied for and approved in advance then reapplied for every six months. The kidney transplant was covered by the Iowa Kidney Foundation.

In mid-1987 I was called early one morning and told to come to the U. of I. Hospital immediately. I spent the next 10 weeks there being poked and filled with drugs. Consequently I'm somewhat nervous about anything more involved than a simple blood test.

I was released after I refused any new treatments. I figured if I wasn't well enough by then, I would never be. At my release, I was taking over 30 pills daily. I had to make repeated trips to Iowa City to make sure the organs were functioning properly. These things—plus the fact I wasn't getting back the strength I'd expected—led to a depression that lasted almost two years. I slept odd

(Continued next page)

hours, ate little and tried to avoid taking my medications. This made me feel even worse because I wasn't strong enough physically or mentally not to take them.

Although everything now works and I have some strength back, I still need to nap, even after doing very little. I take 27 pills a day, many of which have side effects. Susceptibility to skin cancer, cataracts, short term memory loss, weight gain and puffiness in the face are a few. I look like a cross between Charlie Brown and Homer Simpson.

'This type of thing changes your whole perspective on life. I hate when people say "At least you're alive." There is more to life than just being.'

These medicines cost over $600 a month. As of 1992 my private insurance costs over $275 per month, which I need should my medical benefits be canceled or cut. I receive assistance for these expenses and for housing. Basically I'm kept by taxpayers money, which more taxpayers are tired of providing.

The deterioration my body suffered before has not halted, but merely slowed. For example, the recent collapse of a bone in my foot requires me to wear special shoes and supports to prevent further problems. Everytime something seems unusual I call the doctors. I'm so afraid that something minor will become major and mean more drugs, tests and time in the hospital that I feel like a hypochondriac. I think I am merely dying a bit slower now. Maybe the way I was dying before would have been more merciful because I would not have had such false hopes about returning to a normal life. I thought after the transplant I would be able to return and contribute to society.

This type of thing changes your whole perspective on life. I hate when people say "At least you're alive." There is more to life than just being. I find myself more understanding of people who take their own life when they suffer serious medical problems.

On the other hand when I see a healthy person, especially a child who really seems to enjoy life, it does more for me than all the medicine they could give me. Children are the biggest reason I go on because I hope they may benefit from my medical tribulations.

I don't want people to exclude the possibility of a transplant. In the years since mine new developments have arisen. But, patients must ask questions so as not to be disappointed. They should ask about the operation, how they will have to change their lifestyle, what kind of help they may need (physically, financially, mentally), how it will effect other medical problems they may have and what kind of recovery they will experience.

I've met several transplant patients and not many have the problems I have had. Indeed I am stronger than before my transplant, and I manage to take care of myself and do a little volunteer work. I also greatly enjoy being around children. But, I think people need to know they may not return to a normal way of life. They shouldn't get their hopes up too high as to the fullness of their recovery following a transplant.

Things are never as perfect as we might wish.

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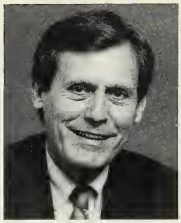
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Paul Romans

Logic and consistency needed in long-term care

Society faces some difficult decisions about long-term care, says the author, executive vice president of the Iowa Health Care Association.

What is the Iowa Health Care Association? What is the organization's primary goal?

The Iowa Health Care Association is a trade association representing Iowa long-term facilities. Our membership consists of 300 licensed profit and not-for-profit facilities, representing over 22,000 long-term health care beds. The Iowa Health Care Association provides resources and education to help our members comply with laws and regulations and achieve the highest possible level of physical, mental and psychosocial well-being for facility residents.

Iowa receives less federal money than other states for long-term care because we have a high percentage of intermediate facilities rather than skilled nursing facilities. Why has this situation continued and what can be done to alter it?

It's true Iowa used to have a higher percentage of intermediate care facilities compared to most other states. Today, however, we no longer have intermediate care facilities in Iowa or nationwide. OBRA 1987 mandated all intermediate care facilities upgrade their services to skilled care as of October, 1990. All facilities that used to be called intermediate care facilities are now called "nursing facilities."

The distinction between intermediate care facilities and skilled nursing facilities is primarily one of care philosophy. Generally, intermediate care facilities use a less expen-

sive "hospitality" model of care. The hospitality model focuses on "high touch" rather than "high tech." Skilled nursing facilities use a sub-acute care model, which requires more staff and specialized medical therapies.

Because we were primarily a state of intermediate care facilities, which required less state spending, Iowa also received less federal matching money than other states.

Along with mandating skilled care, the federal government charged the state with devising a reimbursement methodology to pay for it. Ultimately, the state decided to continue its current system, which places a cap on total reimbursement to a facility.

Unfortunately, this system is unresponsive to actual costs, creates a disincentive for facilities to take "heavy care" Medicaid patients and results in a low reimbursement rate to Iowa's nursing homes.

In order to correct this problem, the state should consider changing its reimbursement methodology to take into consideration the costs of the skilled care model, including paying for specialized ancillary services.

How have OSHA and other government regulations affected Iowa's nursing homes?

OSHA recently began requiring long-term care facilities to offer all employees hepatitis vaccines at no charge and to implement occupational exposure plans. This was mandated in spite of the fact that infection by bloodborne contact is exceedingly rare in long-term facilities.

The OSHA regulation is a prime example of how the federal government often mandates regulations without regard to cost or need. (The estimated cost to implement the OSHA rules is somewhere between $7,000-$15,000 per facility.)

The Iowa Health Care Association recognizes that our industry needs to be held accountable. However, we need to return some common sense into the law and rule-making process to better utilize limited resources.

Also, we must cut through the bureaucracy barriers if we want to retain our professional health care workers. The current regulatory environment does not allow long-term care workers to use their professional judgement as they were trained and educated. Many of the industry's best and brightest, feeling stifled, are leaving long-term care work.

What is the biggest challenge facing Iowa's long-term care facilities in the future?

Our nation faces a quandary about our health care policy. We have used a reactionary approach to setting policy for far too long.

Our population is aging. As a nation, we cannot afford to wait until the baby boomers need long-term care to develop a logical system and a consistent policy.

To determine what we want out of long-term care, as well as from health care in general, we must unify with the medical profession, other health care providers, lawmakers and the public to begin making difficult ethical choices.

In long-term care, if we desire the skilled model with emphasis on technological services and rehabilitation, we need to make our reimbursement system responsive to the cost demands. If we seek a return to the hospitality model, our regulatory environment must change to allow providers to work with the patients and family members toward this end.

No matter what we decide, we must achieve some consensus on what we want and what we can afford.

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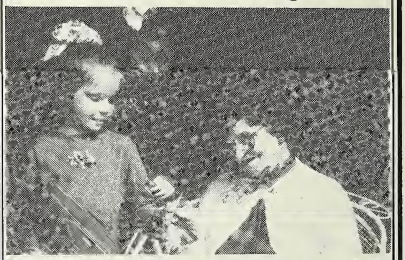
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TWO CLINICAL TRIALS WILL BEGIN in early 1993 for patients with Hereditary Angioedema (HAE), a rare disorder that results from congenital deficiency of the complement regulatory protein C1 inhibitor (C1INH). C1INH prevents uncontrolled classical pathway activation and low levels lead to complement consumption and attacks of angioedema. The prevalence of C1INH deficiency may be as high as 1 in 50,000.

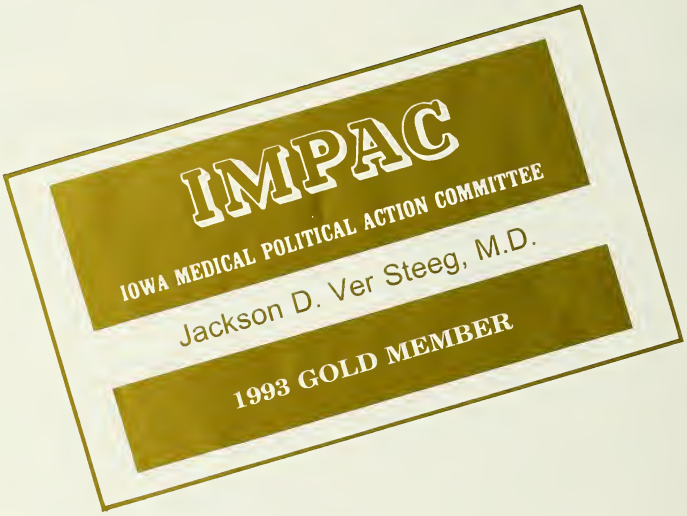
HAE is characterized by flares of angioedema, abdominal pain and throat swelling that may occur spontaneously or after trivial trauma. The average time from onset of symptoms to recognition of this disorder is 21 years. A family history of HAE or sudden death due to choking may alert clinicians to consider this diagnosis but a positive family history is not necessary because C1INH gene mutations may occur spontaneously.

Patients may also present with an "acute abdomen" leading to multiple, unnecessary abdominal procedures before the diagnosis of HAE is made. C4 is virtually always depressed in patients with HAE due to low-grade chronic complement activation, and the level may be undetectable during acute flares. Antigenic C1INH levels may be normal or depressed because about 15% of HAE patients produce antigenically normal C1INH that is non-functional. Thus, the diagnosis requires a low C4 and a low C1INH level (measured either antigenically or functionally).

Patients with HAE are treated phylactically with attenuated androgens for several days prior to surgical procedures. Patients with frequent spontaneous bouts of angioedema may also be treated chronically with androgens. Unfortunately, the management of acute flares of HAE is more difficult because angioedema does not respond to epinephrine, corticosteroids or antihistamines as would be expected for idiopathic or allergic angioedema.

The two clinical trials planned for early 1993 will examine the safety and efficacy of C1INH concentrate in patients with HAE. If you have a patient with HAE, please contact Drs. Karen K. Maves (319/353-6077) and John M. Weiler (319/356-2114) of the UIHC Department of Internal Medicine.

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College of Medicine Highlights

DR. JOHN ECKSTEIN, PROFESSOR OF INTERNAL MEDICINE AND LONGTIME DEAN of the UI College of Medicine, received the American Medical Association Distinguished Service Award for 1992. The award recognizes meritorious service in the science and art of medicine and was one of six major honors presented at the AMA annual convention in June.

FORMER UI INTERIM PRESIDENT RICHARD REMINGTON died July 26, 1992. He was UI Foundation Distinguished Professor of Preventive Medicine and Environmental Health and former vice president for academic affairs and dean of the faculties.

DR. DAVID SKORTON, INTERNAL MEDICINE, was named UI vice president for research, effective August 1. As vice president, he heads the UI research program, which attracted $150 million in grants, gifts and contracts for the 1992 fiscal year. Skorton will also continue as director of the Cardiovascular Research Center's Specialized Center for Research in Coronary and Vascular Diseases, a multidisciplinary center funded by the NIH.

FACTORS INFLUENCING WHERE FAMILY PHYSICIANS LOCATE THEIR PRACTICES have changed over the past two decades, says **Roger Tracy, Office of Community-Based Programs.** Tracy was lead investigator of a study of family physicians who completed three years of specialty training in Iowa's Statewide Family Practice Training Program. Compared to graduates in the 1970s, today's new family physicians are more interested in the quality of local schools, income guarantees, the cost of buying into a group practice, the presence of other family physicians, and employment opportunities for spouses. Several other factors have remained consistently important: size of the community, opportunities for group practice, perceived compatibility with physicians in the group, perceived quality of the local hospital, on-call schedule, and availability of specialists such as general surgeons and obstetricians. The demand for family physicians remains high across Iowa, the Midwest and the nation, Tracy says.

THE UI HAS JOINED THE NIH AIDS CLINICAL TRIALS GROUP PROGRAM that tests new therapies for people infected with the AIDS virus. UI researchers will participate as a subunit of the AIDS Clinical Trials Unit at the University of Minnesota. "The approval of our site is good news for all of our patients," said **Dr. Jack Stapleton, internal medicine,** director of the HIV program at UI Hospitals and Clinics. "It means we will have an opportunity to participate in both clinical and laboratory studies that will expand our understanding of this disease." Co-investigators include **Dr. Bryan Volpp, internal medicine,** who is director of the Iowa City VA Medical Center HIV Clinic.

HONORS: Arthur Benton, neurology, won the Gold Medal Award for Life Achievement in the Application of Psychology, presented by the American Psychological Foundation. Benton was cited for contributions made during his 60-year career as a neuropsychologist, including pioneering clinical studies of brain-behavior relations. . . . **Charles Davis, preventive medicine and environmental health,** is the 1992 recipient of the College of Medicine's Lewis D. Holloway Award for research in health science education. Davis, a biostatistician, developed a program to teach data analysis to medical students. . . . **Dr. Robert Fick Jr., internal medicine,** was recognized by the Iowa Lung Association as the outstanding volunteer for the state. Fick was presented the 1992 Frances Brophy Award in Des Moines. . . . **Dr. Hansjoerg Kolder, ophthalmology,** won the Dr. Ernest Theilen Clinical Teaching and Service Award. The award honors the late Dr. Theilen's contributions to the College of Medicine. Kolder, who conducts research in the electrodiagnosis of eye diseases, maintains an extensive clinical practice and teaches in cataract surgery. . . . **Dr. John Strauss, dermatology,** has been elected to a five-year term as president of the International League of Dermatological Societies. He will also serve as president of the International Committee of Dermatology. . . . **Dr. Richard Wenzel, internal medicine,** has been appointed to the editorial board of the *New England Journal of Medicine.* The *NEJM* is the oldest continuously published journal in the world and has more than 230,000 subscribers. Wenzel is the first Iowan to be appointed to the journal's board.

About IMS Members

Larry Beaty, M.D., has been named Director of Family Practice and Associate Director of Medical Education at Broadlawns Medical Center, Des Moines.

Timothy Blair, M.D., family practice, has joined a medical practice which serves Keosauqua, Bonaparte and Farmington.

Jeffrey Bebensee, M.D., has joined Iowa Physicians Clinic Family Practice, Des Moines.

Donald Young, M.D., Iowa City and **Stephen Van Houten, M.D.,** Ames, have been named fellows of the American College of Radiology.

James Duggan, D.O., Dale Wassmuth, M.D. and **Gerald Brooks, M.D.,** all of Sioux City, have received the National Alliance for the Mentally Ill "Exemplary Psychiatrist" Award.

George Aurand, M.D., Clinton, received an award in recognition of his contributions to and the initiation of Women's Health Services of Clinton.

Nidal Harb, M.D., Clinton, has been selected by Duke University Medical Center to take part in the largest cardiovascular medicine study ever conducted in the U.S.

Harold Eklund, M.D., Des Moines, has been elected president of the Iowa Academy of Family Physicians. Other officers include: **Laine Dvorak, M.D.,** Humboldt, president-elect; **A. Clinton MacKinney, M.D.,** Cresco, vice president and **Thomas Evans, M.D.,** Des Moines, secretary/treasurer.

Marian Barnes, M.D., Cedar Rapids, has been named 1992 Iowa Family Doctor of the Year by the Iowa Academy of Family Physicians.

Charles Driscoll, M.D., Iowa City, has been selected as the 1992 Iowa Academy of Family Physicians Educator of the Year.

The governing boards of **St. Joseph Mercy Hospital** and **North Iowa Medical Center,** Mason City, recently approved a Memorandum of Understanding, specifying the intent of the two organizations to consolidate into one hospital. It is hoped the formal documents will be signed by June 1, 1993.

Terry Dynes, M.D., has been appointed medical director of the Decorah Clinic.

The following physicians have joined Medical Associates Clinic, P.C. in Dubuque: **Peter Tinsman, M.D., Frederick Hamly, M.D.** and **Yasyn Lee, M.D.** All three physicians are new to Iowa.

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Suburethral sling— an old procedure revisited

This procedure is increasing in popularity for certain patients.

Larry Lindell, M.D.
Des Moines

THE SUBURETHRAL SLING PROCEDURE has been used to treat urinary incontinence since 1907.[1] Despite multiple modifications of the procedure, it has the stigmas of technical difficulty and high morbidity. The list of reported complications include urinary retention requiring sling revision, voiding difficulties, urethral irritation, urethral necrosis from excessive sling tension, rejection of synthetic material and infection requiring removal of a synthetic sling. Therefore, this procedure has generally been used only to treat recurrent stress incontinence, usually as a last resort.

Despite this history, the popularity of the suburethral sling as treatment of stress urinary incontinence seems to be rising.

There are several factors that contribute to its rise in popularity. The first of these is a better understanding of the association between surgical failures and the presence of a low urethral closure pressure (LUCP). Sands showed that the Burch procedure fails 54% of the time in women with a LUCP.[2] In other words, a large percentage of women with LUCP are incontinent, even though their urethrovesical junction is restored to its retropubic position.

Dr. Lindell practices obstetrics/gynecology in Des Moines.

The prevalence of LUCP in women with genuine stress incontinence is higher than expected. Horbach noted in a recent retrospective review of 220 patients with stress incontinence that 49% had LUCP; the older patients had the highest incidence of LUCP.[3] The same investigator found that being 50 years old or older was the only clinical finding predictive of LUCP in women with stress incontinence.

Prior incontinence surgery is also associated with LUCP. McGuire found a 13% incidence of LUCP in patients with stress incontinence and no prior surgery compared to a 75% incidence in women who had failed previous incontinence surgical procedures.[4]

A suburethral sling procedure seems to be more effective in achieving continence in patients with stress incontinence and LUCP than the retropubic or vaginal urethropexies. In a group with incontinence and LUCP, Horbach showed that surgical cure was obtained in 80% by performing a suburethral sling procedure compared to a 35% cure rate in a matched group who had a Burch colposuspension.[5] Summit showed that 93% of patients with stress incontinence, a LUCP and urethral hypermobility as defined by the Q-tip test, were cured after a suburethral sling procedure.[6]

This information suggests a suburethral sling is the indicated surgical procedure for patients with LUCP, even if they have had no prior surgery. There are patients with normal urethral closure pressures who should also be

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considered for this procedure. Those who have failed other incontinence procedures and still have urethral mobility are good candidates. Those who have other risk factors for failing an incontinence procedure—obesity, chronic cough, lifestyle containing excessive physical strain—should also be considered.

This expansion of indications for a suburethral sling has been the main reason for its rise in popularity, but several modifications in the technique which seem to decrease morbidity have also contributed. One modification is to use a wider strip of material for the sling. Strips of fascia for the sling are usually only 1-2 cm wide and they tended to roll and act more like a rope than a hammock of support. This narrow band of support can create problems with urethral obstruction, irritation and pressure necrosis. A wider strip of material, (2-3 cm at the place of contact with the urethra), creates a wider distribution of pressure on the urethra with fewer obstructive problems and certainly less erosion into the urethra.

'A suburethral sling procedure seems to be more effective in achieving continence in patients with stress incontinence and LUCP than the retropubic or vaginal urethropexies.'

Synthetic products are required for wider strips since harvesting wide strips of fascia is very difficult. Polypropylene mesh (Marlex), which has been used extensively in abdominal wall reconstruction, is one possible material for suburethral slings. It is strong, host tissues seem to accept it well and fibrous tissue readily incorporates into its pores. Microporous polytetrafluorethylene (Gore-Tex), which is used as a vascular prosthetic material, is gaining widespread use in sling procedures. Bacteria adhere to it less than to Marlex in the presence of infection so it does not have to be removed in the presence of operative bed infection.[7] It also produces fewer adhesions, making it easier to remove.

Horbach et al describe a technique for the suburethral sling procedure which seems to decrease the procedure's morbidity.[8] One improvement is to plicate the urogenital diaphragm over the urethrovesical junction (Kelly plication stitch) before placing the sling. This not only places an extra layer of tissue between the urethra and the graft which helps prevent erosion, but it elevates the urethrovesicle junction so less tension is necessary on the sling to keep this junction in a retropubic position. With this technique, the sling is not acting as the main support of the urethrovesicle junction in the static situation. Rather, it is an immobile shelf against which the urethra is pushed when the patient coughs, hence closing the urethra and maintaining continence.

The purpose of the sling is not primarily to increase the static intraurethral pressure but to increase the pressure in situations of abdominal pressure such as coughing and sneezing. This results in less constant extrinsic pressure being exerted on the urethra and fewer problems with urethral obstruction, irritation and erosion.

Horbach's article also describes using the vaginal finger in the retropubic space to guide the movement of the forceps from the abdominal incision through the retropubic space into the vaginal field. These forceps are used to bring the ends of the sling from the vagina into the abdominal field. By guiding the placement of these forceps with the vaginal finger, rather than "blind" placement, trauma to the bladder can be greatly reduced.

An acceptably low morbidity can be achieved when these technical modifications and inert synthetic materials are used. A procedure used only as a last resort in patients who have failed all other surgical procedures is now becoming a procedure used with little reservation and may be used primarily in patients with stress incontinence and LUCP.

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Want to be a technician?

Richard M. Caplan, M.D.

"MOST DOCTORS DON'T WANT to make hard moral choices. They just want to be technicians."

Ouch! I read that statement recently, but it made me so angry I promptly repressed the source, which reveals how emotional reactions can interfere with being "scholarly." With the passage of a little time I now reflect calmly on the question, liberating myself from the bias of having been socialized for about 40 years into thinking that my medical colleagues and I were professionals, something different—and better—than being a technician. That sounds pretty arrogant and denigrating to technical work and those who perform it. Such work is vital to modern life and those doing it deserve respect and appreciation. But there are differences worth considering.

The quotation above sounds as if technicians are indeed free of hard moral choices. An argument against that assertion comes to mind at once: honesty, integrity, pride-in-work-well-done are surely high order moral attributes. Even so, physicians carry responsibilities that are different—maybe not in kind, if one uses abstract terms like honesty, but surely different in frequency and magnitude, if one thinks of the encounter between patient and doctor, its frequency, its eye-to-eye directness and its gravity for both doctors and patients—not merely as a "possible scenario" that one may probe one's imagination to produce, but as events happening many times daily.

What would cause a (probably) intelligent person to make the claim in my opening quotation? Does that writer really think doctors don't want to encounter the pain and distress of patients' lives rather than bodies; that doctors want to avoid conflict, tension, dilemmas; that doctors want to function as automatons, addressing problems in a standardized way that means no challenge, no strain, no rush of adrenalin, no responsibility—and be higher paid all the while? Might that (probably) intelligent person have made such a claim because of direct personal experience of doctors who convey that impression? If such an impression is indeed faulty—grievously faulty—does it arise because the public is angry, confused, paranoid? Or because doctors spend too little time considering critically their individual and collective behavior. Some of each, maybe?

Robert Burns wished that people might have the power "to see oursels as ithers see us." What if we accepted, as an opening assumption, that the criticisms are largely correct, instead of largely incorrect? Because defensiveness clouds vision and judgement, especially of oneself, it's easier, if we do admit imperfections in doctorly behavior, to concede them as coming from some small fraction of other doctors. To introspect about one's own weaknesses usually stimulates lots of denial. To break through that protective crust to reveal ourselves as others perceive us can certainly feel painful. That surely explains some of the negative responses among physicians toward efforts named "medical audit," "peer review" or "quality assessment and improvement."

What can or should physicians do who want to be part of the solution rather than part of the problem? Reading and listening to the critical voices with an open mind could be a good beginning. After absorbing the spirit of the critique, and perhaps a few of the details and examples, make the effort to assess one's own behavior and the environment we each control. It's hard. It needs doing, though.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

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Already the administrator of a Des Moines ophthalmology clinic, I was offered the chance to manage a second ophthalmology clinic in Ames, 40 miles away. I approached my physician employers with the topic of "shared management" and was impressed by their open-mindedness. Little did I realize the full impact this arrangement would have on both clinics. Shared management has opened the door for me to combine resources and pursue volume discounts that directly affect the entire office overhead.

How it works

I spend 2½ days in Des Moines and 2½ days in Ames each week. My salary is paid equally by both groups but my check, benefits, profit sharing and pension are handled through one clinic. Both groups are single specialty ophthalmology, which means they both have a great deal in common as far as medical supplies and equipment utilization.

First year advantages

One of the top priorities was upgrading the computer system. Fortunately, both clinics had the same system and both were open to the idea of upgrading. By sharing acquisition of a computer system, each group got a $6,000 discount savings. In addition, patient registration, billing, scheduling and word processing was shared by each group which allowed for improvement of joint operations. Subsequently, computerized payroll and accounts payable were completed with similar findings.

Both groups were able to combine volume discount rates on routine office supplies 35% below what they had been paying.

Another area of expansion included the need for an ophthalmic technologist. Each group had only part-time openings, but through combining the two groups, we were able to attract a qualified individual to share job duties at both clinics.

Do the practices compete?

A major concern in shared management is each clinic's drawing area and the extent to which the practices actually compete. Shared management would not be advisable for practices in direct competition because of the administrator's role in increasing market share. In these cases, a merger would be more appropriate.

There are also regional political issues that occasionally arise. These have been resolved by physician interaction.

I'm not saying shared management is the only desirable clinic management plan, but I endorse it whole-heartedly. The economic rewards enjoyed by the clinics prove shared management is a wise investment.

This article was written by Randy Eckard, clinic administrator for Des Moines Eye Surgeons, Des Moines, and Iowa Eye Care Physicians, P.C., Ames. He is a member of the Iowa Medical Group Management Association.

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Nonautonomous patients

Robert Weir, Ph.D.

WE DISCUSSED AUTONOMOUS PATIENTS in the October column, noting that the language of "autonomous/nonautonomous" patients is preferable for several reasons to the traditional language of "competent/incompetent" patients. For patients to be autonomous in a general sense, they must have the capacities for understanding, deliberation and voluntariness in decision making. If they are being asked to make a high-stakes decision, such as a decision to accept or refuse life-sustaining treatment, they need additionally to have the capacities for authenticity, communication and appreciation of the personal significance of the decision.

One of the advantages of using the newer language is simple: autonomy is a flexible concept that fits the diversity of medical reality better than does the language of competency. Many patients possess all of the capacities mentioned above and are clearly autonomous. Other patients lack these decision-making capacities and therefore are nonautonomous. An unknown number of patients fall in the middle of the autonomous/nonautonomous spectrum and are described as having underdeveloped autonomy (some adolescent patients), fluctuating autonomy (some psychiatric patients, some geriatric patients) or diminished autonomy (some patients with depression, patients with mild dementia, some geriatric patients and some confused patients).

Nonautonomous patients can be classified according to the type of incapacity. Such a classification scheme should distinguish among patients in at least the following categories: patients who are nonautonomous in relation to important health decisions because of young age and immaturity (typically, pediatric patients under the age of 14), patients with substantial incapacity to make decisions because of severe to profound mental retardation, brain damage or the complications of multiple-organ failure and patients with permanent loss of consciousness. Adult patients who have fluctuating or diminished capacity to make decisions (because of mental illness, shock or organic brain syndrome) often end up as examples of a fourth category, at least when decisions in individual cases require an either/or determination by the attending physician of a patient's decision-making capacity.

The importance of determining whether a patient is autonomous or nonautonomous is obvious. An adult patient who is autonomous has the moral and legal right to consent to recommended medical treatment and to refuse any medical treatment (including life-sustaining treatment), regardless of views held to the contrary by the patient's physician(s) or family.

A previously autonomous adult patient who now lacks decision-making capacity retains the moral and legal right to refuse treatment, but the refusal has to be communicated through the patient's earlier known preferences (preferably an advance directive) or by a surrogate making a decision based on the patient's best interests. For adult patients who have never been autonomous, the only acceptable standard for abating life-sustaining treatment is a determination by the patient's surrogate that such treatment is contrary to the patient's best interests. For nonautonomous patients who have no surrogate, any decision not to initiate or continue life-sustaining treatment should be based on the patient's best interests and made with great care, either by a multidisciplinary care committee or an institutional ethics committee. In some institutions, the appointment of a guardian may be deemed necessary.

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.

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William Eversmann, Jr., M.D.

What's in a name?

And the best and the worst of this is
that neither is most to blame
If you have forgotten my kisses
and I have forgotten your name
—An Interlude by Swinburne, 1866

AS SWINBURNE POINTS OUT to us, remembering a name can be important. All the more vital if the name is easily confused with others.

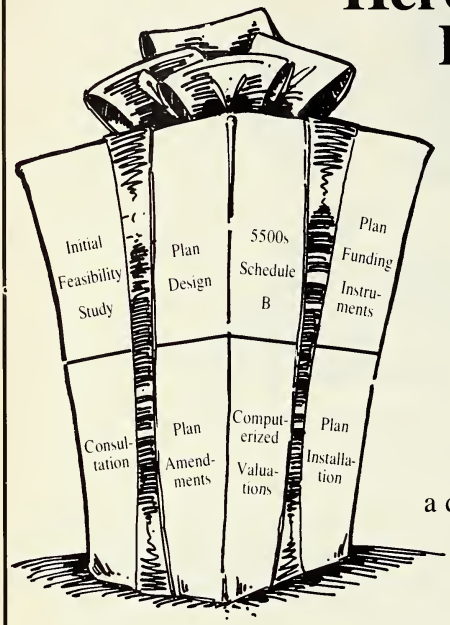
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During the most recent academic year, the IMS Education Fund provided $178,220 in loans to 43 medical students. The work of the Education Fund, however, is not limited to medical education. The Dr. Henry Albert Physician Benevolence and Public Health Fund which has received over $316,000 from its source since the mid-1960s continues to make money available to needy physicians and their widows and supports programs such as the IMS Assistance Program for Troubled Physicians, the Hawkeye Science Fair and a variety of other educational and public health projects. As Iowa physicians, we continue to be a primary source of funding for these activities through the IMS Education Fund and the Iowa Medical Society. In 1991, 424 physicians contributed over $21,000 to the IMS Education Fund. It is only through the generous support of physicians that this vital work can continue.

Realizing that physicians several times each year are asked to contribute to a variety of worthy causes, it seems even more important now that there be no confusion concerning the name or purpose of the charitable organization associated with our medical society. I ask all of you—if you have not already done so with the renewal of your membership to the Iowa Medical Society—to support the IMS Education Fund and its vital work of medical education, support of needy physicians and their widows as well as a variety of health-related education projects and public health projects. That's what's in the name, IMS Education Fund. We the physicians of Iowa are its support.

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Marion E. Alberts, M.D.

There is hope

As I reflect upon my past pediatrics practice I am sure that the most difficult part was to inform a child's parents of an unfavorable diagnosis. Whether a deformity of a newborn infant, a serious illness, an incurable malignancy or death, the task was never easy and it never became easier through the years. Physicians are often pictured as being cold about such events. Inside we are as upset as the child's family.

My first encounter with this experience was as a resident physician during the poliomyelitis epidemics of the late 1940s and early 1950s. I still have visions of a beautiful little girl, ill only a day or so, who entered the hospital in the morning afflicted with severe bulbar poliomyelitis. Measures available at that time were ineffective; she died later the same day. I learned that it is a tremendous test of faith to accept such a tragedy.

Timothy was another child who remains in my memory. He was a failure to thrive infant. Yet, the mother with hope in her voice noted that Timothy was gaining weight—his abdomen was fatter. There was enormous enlargement of both kidneys; bilateral Wilms' tumors. He did not survive exploratory surgery.

Danny was an attractive young boy brought to me for evaluation of a limp. Examination revealed a markedly enlarged liver. Surgical exploration demonstrated a far-advanced hepatoma. Danny died on the operating table.

Another child was seen in the emergency room because while on vacation she seemed less active. Her color was waxen and pale. Within an hour or so the diagnosis was evident—acute lymphatic leukemia. The parents were unwilling to accept the diagnosis at first. Fortunately the child responded to medical treatment.

So much for reflections of the past. This issue of *IOWA MEDICINE* features the subject of cancer. Much can be done for victims of cancer, as well as other serious illnesses. I am fortunate that I had the opportunity to practice medicine during an era of tremendous advances in technology in the fields of diagnosis and treatment. We have the means available to diagnose more quickly and accurately; we have the therapeutic agents; we have the knowledge. We can provide more assurance of successful management. But, the fact remains that early diagnosis is the key to successful treatment. We must continually educate our patients of the early signs and symptoms; we must be alert to the possibilities. Our protocols of therapy are improving each year. The children upon whom I have reflected would have had a better chance today to live and be well.

MERCY HOSPITAL MEDICAL CENTER
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PRESENTS

ORTHOPEDIC UPDATE IN PRIMARY CARE

MARCH 24, 1993

GUEST FACULTY	TOPICS
FRANK SCHMID, M.D. PROFESSOR OF MEDICINE DIVISION OF RHEUMATOLOGY NORTHWESTERN UNIVERSITY MEDICAL SCHOOL CHICAGO, ILLINOIS	**"INFECTIOUS DISEASES OF BONE, JOINTS AND BURSAE"**
ROBERT COFIELD, M.D. ASSOCIATE PROFESSOR OF MEDICINE MAYO MEDICAL SCHOOL ROCHESTER, MINNESOTA	**"ARTHRITIS OF THE SHOULDER"**
FRED DIETZ, M.D. ASSOCIATE PROFESSOR, ORTHOPEDIC SURGERY UNIVERSITY OF IOWA HOSPITALS/CLINICS IOWA CITY, IOWA	**"ADOLESCENT LEG PAIN"**
ERNEST FOUND, M.D. ASSOCIATE PROFESSOR, ORTHOPEDIC SURGERY UNIVERSITY OF IOWA HOSPITALS/CLINICS IOWA CITY, IOWA	**"LOW BACK PAIN"**
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Patients benefit if cancer specialists, family physicians communicate

Cancer patients often have needs the specialist can't fill. This oncologist discusses the special role family physicians can play when their patients are undergoing treatment for cancer.

PRIMARY CARE PHYSICIANS SHOULD not be relegated to the background when their patients are being treated for cancer, says an Iowa oncologist.

"A patient benefits greatly if the primary care physician and the specialist work together during the cancer treatment," comments Dean Gesme, M.D., a Cedar Rapids oncologist and president of the Iowa Division, American Cancer Society. "We specialists look to family physicians to remain involved in several key areas."

The first and most crucial is in the area of emotional support for patients dealing with the disbelief, anger and anxiety that accompany a diagnosis of cancer.

"Cancer patients need so much emotional support and their family physician is often in the best position to offer it," says Dr. Gesme. "Some patients get very angry and stay that way. Others don't get angry at all. Some are disbelieving. There are patients who, for weeks and weeks, deny the diagnosis. Every patient reacts differently and the patient's family physician is in the best position to know how a patient will cope with this disease and what resources they have in this time of stress."

The patient's primary care physician can help a patient "redirect the anxiety and denial in a productive way," adds Dr. Gesme.

"It's human nature to want to find out what caused a problem and what we can do to fix it. A diagnosis of cancer goes against common sense and can evoke some emotions that can be very difficult to deal with."

Emotion-filled atmosphere

Family physicians can also play a key role as mediators in helping patients understand their diagnosis and treatment plans.

"A specialist probably doesn't know the patient very well and might overestimate their level of understanding. Also, the atmosphere is so emotion-filled that it often prevents a clear understanding of what the oncologist is saying," adds Dr. Gesme. "When patients are told they have cancer, it's difficult for them to assimilate huge amounts of information about their diagnosis and prognosis."

Consequently, the patient may go back to the family physician later for a second explanation or further information.

"Talking to their family physician is a great way for the patient to reinforce what they have heard or be reassured about certain treatment options," he says. "The patient is closer to the family physician and that physician's word probably carries more weight. That physician is in a better position to help educate the patient and redirect their emotions."

Though Dr. Gesme says miscommunication between family physicians and oncolo-

(Continued next page)

gists is "infrequent," he believes patients would benefit if communications were more open. The problem, he explains, is not knowing how involved the primary care physician wants to be in the cancer treatment.

"It's a matter of being sensitive to the desires of the individual doctor and reaching a compromise. Some family physicians want daily reports on a patient's status; others are comfortable being less involved. Some of us consultants do a better job of communicating than others. Problems arise when assumptions are made which probably shouldn't be made."

Complex situations arise quickly

One problem, he says, is that family physicians sometimes don't feel qualified to deal with a patient being treated for cancer.

"Sometimes the family physician can end up having to care for the patient when complications arise. Cancer treatment can cause severe situations such as acute infections or allergic reactions that develop very quickly," he explains.

This situation can be even more problematic when the patient lives in a rural area far from the specialist.

"Maybe the patient has had cancer treatment the day before, and the family physician doesn't even know what the treatment entailed." Dr. Gesme says. "It's important for the physician to have the knowledge to determine whether it's the treatment or the cancer that's causing the problem."

In some states, there are courses for primary care physicians in rural areas on how to deal with cancer and cancer treatment complications in their patients and Dr. Gesme believes there should be more emphasis on this subject in physician training.

Dr. Gesme's feels strongly that the primary care physician and the specialist should be able to communicate freely about their patient.

"The patient's family physician should make use of the oncologist at any time for any reason to the full extent of their needs. They should ask questions and be persistent. If a family physician wants to continue providing medical care for the patient, they should tell the specialist. If they want to turn it over to us, they need to let us know that, too. We need to make use of each other's abilities."

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(includes course materials, breakfast, lunch and refreshments)

Registration Deadline is February 18, 1993.
Registration is limited. For registration information, please contact June Zenisek, R.N., Symposium Coordinator, 319-362-5118 or 1-800-728-5118.

Agenda

8:30	Registration
9:00	Opening Remarks—Dr. Ersin Atay
9:15	Atrial Fibrillation: New Ideas on an Old Arrhythm Dr. Greg Flaker
10:00	Interventional Cardiology in the 90's— Dr. Michael Winniford
10:45	Break
11:00	Healthcare in the 90's: Cost versus Technology- Dr. Robert L. Replogle
11:45	Question Session
12:15	Lunch
1:15	The Significance of Cholesterol in Childhood— Dr. Ronald M. Lauer
2:00	Break

Concurrent Workshops

2:15	—Mitral Valve Prolapse—Dr. Todd Langager —Peripheral Vascular Disease—Dr. Kevin Kope —Rehabilitation of the Cardiac Patient— Dr. David Rater
3:00	Break
3:15	—Echocardiograms in Congenital Heart Diseas Dr. Stephen Roth —Innocent Heart Murmurs—Dr. Ronald Lauer —Medical Case Studies—Dr. Richard Fleming
4:00	Evaluations

Cancer rates and treatment options both increase for Iowans

Cancer rates among Iowans have increased in the past 20 years, but so have possible treatments for people diagnosed with certain types of cancer, say two experts from the University of Iowa's Department of Internal Medicine.

Gerald Clamon, M.D.
Charles Lynch, M.D., Ph.D.
Iowa City, Iowa

What are the most significant recent developments in radiation and chemotherapy treatments for cancer?

New advances include the development of new agents for the treatment of cancer: Fludarabine for chronic lymphocytic leukemia, Chlorodeoxyadenosine for hairy cell leukemia and Taxol for ovarian cancer. Taxol may also be promising in breast cancer, melanoma and lung cancer.

Other new drugs showing promise include Camptothecan and related drugs for treatment of a broad range of tumors.

In colon cancer, 5 Fluorouracil and Levamisole as adjuvant therapy for patients with resected Dukes C colon cancer have demonstrated that recurrence rates can be decreased with therapy. Patients with Dukes C disease and selected patients with Dukes B2 disease (either with a colon or rectal cancer primary) should be considered for adjuvant therapy.

For selected patients with node negative breast cancer, adjuvant therapy with Tamoxifen or chemotherapy may also reduce the relapse rate. Patients with an excellent prognosis—such as women with tumors under 1 cm—do not need such adjuvant therapy.

In radiation therapy, there are indications twice daily therapy may be an improvement in the control of some cancers. In patients with locally advanced head and neck cancer and in some patients with limited small cell lung cancer, BID fraction radiation therapy may be important in disease control. Ongoing studies will likely further define the utility of such therapy.

An important advance in cancer therapy falls in the area of supportive care. Use of erythropoietin, G-CSF and GM-CSF to improve blood counts post therapy has made it possible for patients to tolerate intensive therapies with less risk of neutropenic infection or anemia. Newer growth factors are under experimental trial and will likely be an improvement since they will also support platelet recovery. IL-3 is one such new growth factor under investigation.

What types of cancer are showing the highest treatment success rate?

Hodgkins disease, non-Hodgkins lymphomas, choriocarcinoma and testicular carci-

(Continued next page)

noma remain among the most curable, even in patients with advanced disease. Hairy cell leukemia is now a potentially curable disease with 2-chlorodeoxyadenosine.

For patients with common epithelial cancers such as colon cancer, lung cancer, bladder cancer, and breast cancer, combinations of surgery, adjuvant or neo-adjuvant therapy and radiation therapy have proved successful in patients who were not surgically resectable. The use of such neoadjuvant therapy (chemotherapy to reduce a tumor prior to surgery) is being tested in national trials.

Intensive chemotherapy with autologous bone marrow transplant to rescue from the side effects of chemotherapy can be a curative therapy in patients with acute leukemia, chronic myelogenous leukemia, refractory Hodgkins and non-Hodgkins lymphomas and perhaps breast cancer.

Are more Iowans getting cancer?

Since 1973, the cancer experience of Iowans has been monitored through the State Health Registry of Iowa. The number of Iowans annually diagnosed with cancer has been increasing. In 1973, the number of malignant cancers diagnosed was 10,100. This increased to 13,000 in 1990.

During this time period Iowa's total population and age-distribution have changed. Because of this, a mechanism has been established to obtain age-adjusted cancer rates per 100,000 population. These rates allow for a better assessment of population changes in cancer frequency over time.

In 1973, this rate for all malignant cancers in Iowa was 307.4. The rate increased to 355.0 in 1990. Between 1973 and 1990, the rate for malignant cancer in Iowa increased 15.5%. The increase has occurred in a steady and gradual manner among men and women.

What role does the patient's primary care physician play in radiation or chemotherapy treatment? How can the specialist help the patient's family physician in educating the patient about the effects of these treatments?

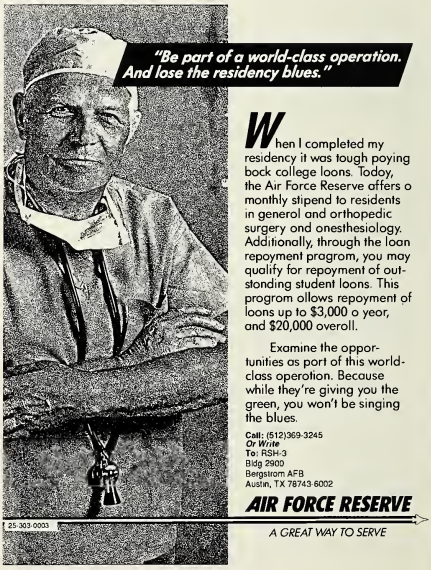
The majority of cancer care is likely given by the patient's primary care physician. From the beginning, the close relationship between the patient and physician leads many patients to ask their primary physician if they should take therapy.

The primary physician can help the patient consider the goal of the therapy. Is the specialist offering a potentially curative therapy? Is the proposed therapy possibly going to prolong life? Is the therapy apt to ameliorate any side effects of the cancer? If the goal of therapy is to ameliorate side effects but not cure or prolong life, the patient may want to weigh the risks of therapy versus the symptoms being treated.

In a patient under chemotherapy, control of nausea or vomiting once the patient goes home is often a major problem. In patients who have received chemotherapy recently, nausea or vomiting may be controlled with Ondansetron 0.15 mg/kg every 4 hours if standard anti-emetics have not worked.

Patients who have a neutrophil count under 1000 and any significant infection or temperature over 100, must be hospitalized for broad spectrum antibiotics after cultures are obtained.

For almost all patients with petechiae, epistaxis or other bleeding and a platelet count under 20,000 or falling, platelet transfusions will be needed.



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Letter to the Editor

Scott County was willing to accept small sacrifice

Dear Editor:

The Scott County Medical Society was disappointed to learn that HCFA has denied the IMS request that Iowa be converted to a single statewide payment area for Medicare reimbursement. Reason for the denial, according to HCFA, was that 70% of the "losing" physicians in areas 01 and 05 opposed the change.

We want the physicians of Iowa to know that the Scott County Medical Society voted in May, 1992 to support the single payment area, even though it would mean a decrease in Medicare reimbursement for those of us in area 01. In the interest of fairness we were willing to accept a slight reimbursement decrease if it meant fairer reimbursement for the hard-pressed physicians who serve rural Iowa.

The government is seeking to reduce the number of Medicare reimbursement areas in the nation, and this would have been a major step toward more regionalized rates.

If we truly believe in the goals of the Iowa Medical Society, it is apparent that some of us may have to sacrifice for the good of the many. The Scott County Medical Society voted to accept this small sacrifice in the interest of fairness and in the belief that a single Medicare reimbursement area would have long-term beneficial effects for Iowa physicians and our patients.—*Mary Hoppa, M.D., Davenport*

Tribute to a friend

Emmett Mathiasen, M.D.
Council Bluffs

Editor's note: Dr. Max Olsen, a family physician from Minden, died December 3, 1992. Dr. Olsen was very involved in organized medicine. He was a past president of the Pottawattamie-Mills County Medical Society and was also very active in the Iowa Medical Society. Dr. Olsen practiced 42 years, all of them in Minden. Dr. Mathiasen and Dr. Olsen were close friends of many years.



Max Olsen, M.D.

MAX OLSEN WAS A CARING family physician in a rural community, treating patients of at least four generations. He helped bring about access to quality care through his work in the medical field and with the Iowa Medical Society.

Max touched people in numerous ways, having friends in all walks of life and probably in every state in the country. He was a humble man who did not brag about all the things he did, letting his deeds speak for themselves.

His many loves, besides friends and patients, included animals and farming, conservation (he planted hundreds of trees at Westfair in Pottawattamie County), woodworking (including making gadgets for friends), 4-H work, fairs, going "shopping" at stores and auctions and best of all, visiting with anyone, always with a smile on his face.

As long-time friends, Art Sciortino and I will miss Max's almost daily phone calls, checking on our welfare and making plans for frequent lunches.

To change an old expression, under "friend" in the dictionary should be Max Olsen's picture.

He worked hard and long and now deserves his rest.

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About IMS Members

New members *(as of January 21, 1993)*

Robert Hinnen, M.D., family practice, Burlington
Leroy Travers, M.D., radiology, Burlington
Karl Kreder, M.D., urology, Iowa City
James McCoy, M.D., urology, Iowa City
Kevin Mulhern, M.D., cardiology, Iowa City
Jerold Woodhead, M.D., pediatrics, Iowa City
Gary Aragon, M.D., resident, Iowa City
Steven Davis, M.D., resident, Iowa City
Jennifer Palmer, M.D., resident, Iowa City
John Rogers, M.D., resident, Iowa City
Kaza Basavapunna, M.D., psychiatry, Clinton
Louis Flores, M.D., family practice, Muscatine
Barry Marun, M.D., orthopaedics, Muscatine
Andrew Andersen, M.D., family practice, Bettendorf
Mark Iltis, M.D., family practice, Bettendorf
James Putman, M.D., family practice, Bettendorf
Todd Ridenour, M.D., neurosurgery, Davenport
Douglas Workman, M.D., family practice, Bettendorf
Brent Feller, M.D., anesthesiology, Cedar Rapids
Edwin Castaneda, M.D., orthopaedics, Dubuque
John Lorenz, M.D., psychiatry, Dubuque
Mark Moore, M.D., internal medicine, East Dubuque
Charles Morrow, M.D., orthopaedics, Dubuque
Mark Niemer, M.D., rheumatology, Dubuque
Leslie Riley, M.D., internal medicine, Dubuque
Peter Tinsman, M.D., obstetrics/gynecology, Dubuque
Rhett Eckmann, M.D., resident, Mason City
Brian Hass, M.D., resident, Mason City
John Ingram, M.D., resident, Mason City
Paul Matthews, M.D., resident, Mason City
Djonggi Situmeang, M.D., resident, Mason City
Jeffrey Wilwert, D.O., family practice, Oelwein
Joan Harding, M.D., family practice, Belle Plaine
Sushil Upadhyay, M.D., psychiatry, Independence
Jerald Phipps, D.O., family practice, Boone
Steven Hallberg, M.D., internal medicine, locum tenens
James Shehan, M.D., internal medicine, Albia
Douglas Weedman, M.D., family practice, Ottumwa
Caroline Boehnke, M.D., obstetrics/gynecology, West Des Moines
Kent Kunze, M.D., child/adolescent psychiatry, Des Moines
Karla Cheney, M.D., resident, Des Moines
Mark Schultz, D.O., family practice, Storm Lake
Garth Purves, M.D., neurosurgery, Sioux City
Roger Weste, M.D., resident, Sioux City

Deceased members

Dean Dutton, M.D., 84, life member, family practice, Van Horne, died December 23
Gerald Larson, M.D., 69, family practice, Elk Horn, died December 16
Patricia Hicks, M.D., 70, family practice/gynecology, Iowa City, died December 7
Aida Belarmino, M.D., 54, pediatrics, Davenport, died November 22
Max Olsen, M.D., 72, family practice, Minden, died December 3
Fortunato Neglia, M.D., 77, life member, family practice, Maxwell, died October 7
Eugene Wiemers, M.D., 81, life member, psychiatry, Davenport, died October 30
John Bakody, M.D., 78, life member, neurological surgery, Des Moines, died December 29

Miscellaneous

Nancy Andreasen, M.D., Iowa City, has been named editor of *The American Journal of Psychiatry.*
Douglas Dorner, M.D. and **David Stubbs, M.D.** were recently recertified in general vascular surgery by the American Board of Surgery.

Items in this column are compiled from IMS membership department records. News from individual physicians, clinics and hospitals is welcomed. Send news items to: "About IMS Members" c/o IOWA MEDICINE, 1001 Grand Avenue, West Des Moines, Iowa 50265.

College of Medicine Highlights

THE NUMBER OF HOSPITAL-ACQUIRED INFECTIONS could be reduced by 25% if health care workers washed their hands with chlorhexidine, an antimicrobial soap, instead of using soap and alcohol, report **Drs. Richard Wenzel** and **Bradley Doebbeling, internal medicine.** The results of their eight-month study that involved 1,894 adult patients in three intensive care units were reported in the *New England Journal of Medicine.* They reported 152 infections when chlorhexi-

(Continued next page)



dine was used versus 202 when the alcohol-soap combination was used. While the use of the antimicrobial soap helped reduce the incidence of hospital-acquired infections, such infections could be further reduced if health care workers washed their hands more often, as recommended under accepted protocols, the researchers noted.

THE GENE FOR BEST'S DISEASE, a rare, potentially blinding eye disease, has been mapped to chromosome 11 by College of Medicine researchers. The work is a major step toward isolating the Best's disease gene which the investigators hope will eventually provide clues to the cause of age-related macular degeneration, the most common cause of legal blindness in older people. The study was directed by **Dr. Edwin Stone, ophthalmology;** co-director was **Dr. Val Sheffield, pediatrics. Dr. Alan Kimura, ophthalmology,** collaborated on the project.

INJURIES SUCH AS BACK OR NECK PAIN, which build up over time instead of occurring in a single accident, are often not identified as work-related and may not be covered by workers' compensation, reports **Thomas Cook, physical therapy** and **preventive medicine and environmental health.** Cook is investigating the incidence of long-term cumulative injuries among construction workers as part of a joint program between the UI and the Eastern Iowa Construction Alliance. While the construction industry has the fifth largest work force in the country and the third highest death rate, many construction workers are more likely to be affected by injuries resulting from cumulative traumatic effects of their work than from instantaneous injuries such as a fall. In a survey of 536 construction workers in eastern Iowa, nearly four in five workers reported that low-back pain caused them to miss work in the 12-month period prior to the study.



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Friday, April 30, 1993: The Throckmorton Surgical Society Symposium on Breast Cancer

Guest Faculty

John M. Bedwinek, M.D.
Director, Radiation Oncology
St. Joseph's Hospital Cancer Center
St. Louis, Missouri

Blake Cady, M.D.
Professor of Surgery
Harvard Medical School
Chief of Surgical Oncology
New England Deaconess Hospital
Boston, Massachusetts

Frank E. Gump, M.D.
Chief, Surgical Service
Department of Veterans Affairs
Professor of Surgery
UMDNJ/New Jersey Medical School
East Orange, New Jersey

Peter R. Jochimsen, M.D.
Professor, Surgery
University of Iowa College of Medicine
Director, Surgical Oncology
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Karl G. Kardinal, M.D.
Ochner Clinic
New Orleans, Louisiana

Richard J. Field, M.D.
General Surgeon
Centreville, Mississippi

Topics

- *Postmastectomy Irridation: What is Its Role Today?*
- *Limitations of Mammographic Screening*
- *Breast Conservation Surgery: Patient Selection*
- *Treatment of Noninvasive Breast Cancer*
- *Contemporary Therapy of Early Breast Cancer*
- *Management of the High Risk Breast Patient*
- *Tamoxifen Breast Cancer Prevention Trial*
- *Pitfalls of Needle Localization and Sterotactic Techniques*
- *Rationale for and Status of the NSABP Prevention Trial*
- *Management of Locally Advanced and Inflammatory Breast Cancer*
- *Update on Adjuvant Therapy of Breast Cancer*
- *Surgery in Rural America*

Saturday, May 1, 1993: Iowa Academy of Surgery Meeting

Speakers

William W. Eversmann, Jr., M.D.
President, Iowa Medical Society
Orthopedic Surgeon
Cedar Rapids, Iowa

Roger D. Tracy
Assistant to the Dean/Director,
Office of Community-Based Programs
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Daniel K. Zismer, Ph.D.
Principal, Director and Co-Founder
of Partners Consulting Group, Ltd.
Minneapolis, Minnesota

Topics

- *Presentation of Resident Competition Papers and Awards at the Scientific and Clinical Session*
- *The Future of Health Care Reform in Iowa: Where is Iowa Going?*
- *The Future of Rural Medical Care in Iowa*
- *Hospital-Physician Relationship in the '90s*
- *Panel Discussion: Where is the Solo Physician Going? Crystal Ball Predictions*

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FACTS ABOUT **CANCER** IN IOWA

During 1993, cancer will cause one of every four deaths

During 1993, Iowans will develop 14,000 new cancers

Five out of six cancers occur in Iowans 55 and older

Lung cancer causes one in four deaths

Prostate cancer will comprise one-fourth of the new cancer cases in men

Breast cancer will comprise 30 percent of all new cancer cases in women

In 1993, an estimated 6,350 Iowans will die from cancer, ten times the number caused by auto fatalities. These projections are based on data from the State Health Registry of Iowa. The registry has been recording the occurrence of cancer in Iowa since 1973.

As one of ten registries in the country funded by the National Cancer Institute (NCI), Iowa represents the rural and Midwestern populations and provides data found in many NCI publications.



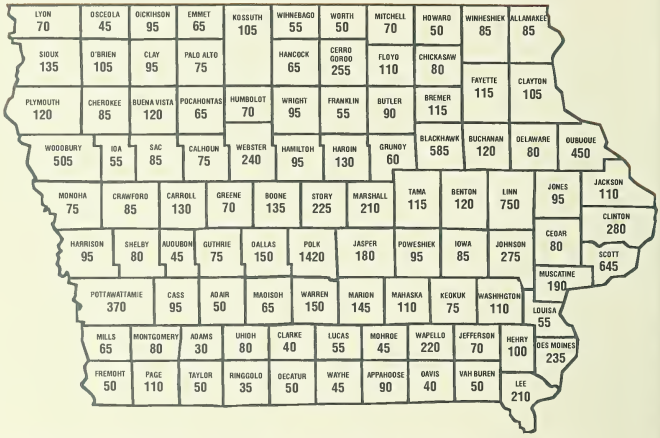
The State Health Registry of Iowa is located at The University of Iowa in the College of Medicine's Department of Preventive Medicine and Environmental Health. The staff includes more than 50 people. Half of them, situated throughout the state, regularly visit hospitals, clinics, and medical laboratories in Iowa and neighboring states. In 1993, data will be collected on 14,000 new cases among Iowa residents. A follow-up program tracks more than 97 percent of the 250,000 Iowans diagnosed with cancer since 1973. This program provides regular updates to keep the data current and useful.

This excerpt provides information from the State Health Registry's annual publication *Cancer in Iowa.*

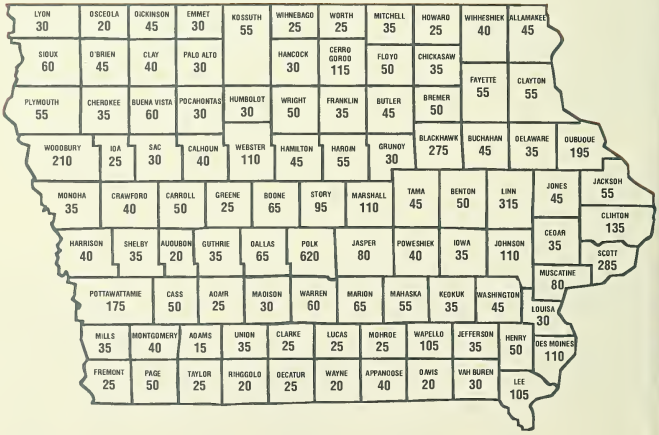
CANCER PROJECTIONS FOR 1993

Cancer occurs throughout the state and affects Iowans of all ages and in every walk of life. In 1993, cancer will strike four out of every 1,000 Iowans and bring death to two of them.

ESTIMATED NUMBER OF NEW CANCERS IN IOWA FOR 1993



ESTIMATED NUMBER OF CANCER DEATHS IN IOWA FOR 1993



TOP 10 TYPES OF CANCER IN IOWA ESTIMATED FOR 1993

Among women, cancers of the reproductive organs, including breast, ovary, uterus, and cervix, comprise more than 40 percent of all new cancers. Lung cancer is on the rise as the leading cause of cancer deaths.

New Cancer in Females

SITE	# OF CASES	% OF TOTAL
BREAST	2080	29.6
COLON & RECTUM	1080	15.4
LUNG	710	10.1
UTERUS	430	6.1
OVARY	350	5.0
NON-HODGKIN'S LYMPH.	300	4.3
LEUKEMIA	170	2.4
PANCREAS	170	2.4
SKIN MELANOMA	165	2.4
CERVIX	155	2.2
ALL OTHERS	1410	20.1
TOTAL	7020	

Cancer Deaths in Females

SITE	# OF CASES	% OF TOTAL
LUNG	585	19.2
BREAST	565	18.5
COLON & RECTUM	445	14.6
OVARY	190	6.2
PANCREAS	160	5.2
NON-HODGKIN'S LYMPH.	145	4.8
LEUKEMIA	120	3.9
KIDNEY & RENAL PELVIS	80	2.6
BRAIN	70	2.3
UTERUS	65	2.1
ALL OTHERS	625	20.5
TOTAL	3050	

Prostate cancer comprises over one-fourth of all new cancers in men and continues a decade-long rise in occurrence. Lung cancer causes one-third of all cancer deaths in men.

New Cancer in Males

SITE	# OF CASES	% OF TOTAL
PROSTATE	1870	26.8
LUNG	1450	20.8
COLON & RECTUM	1030	14.8
NON-HODGKIN'S LYMPH.	275	3.9
BLADDER	255	3.7
LEUKEMIA	230	3.3
KIDNEY & RENAL PELVIS	190	2.7
SKIN MELANOMA	175	2.5
PANCREAS	155	2.2
ORAL CAVITY	150	2.1
ALL OTHERS	1200	17.2
TOTAL	6980	

Cancer Deaths in Males

SITE	# OF CASES	% OF TOTAL
LUNG	1100	33.3
PROSTATE	445	13.5
COLON & RECTUM	390	11.8
PANCREAS	150	4.5
NON-HODGKIN'S LYMPH.	140	4.2
LEUKEMIA	135	4.1
BLADDER	95	2.9
ESOPHAGUS	80	2.4
BRAIN	80	2.4
KIDNEY & RENAL PELVIS	80	2.4
ALL OTHERS	605	18.3
TOTAL	3300	

Cancer remains the second most common cause of death. Over the past 25 years, deaths from heart disease have markedly decreased while cancer has continued a steady increase. If these trends continue, cancer will become the leading cause of death early in the next century.

TOP 10 CAUSES OF DEATH IN IOWA ESTIMATED FOR 1993

CAUSE	NO.	PERCENT
HEART DISEASE	9000	32.7
CANCER	6350	23.1
CEREBROVASCULAR DISEASE	2050	7.5
CHRONIC OBSTRUCTIVE & PULMONARY	1250	4.5
PNEUMONIA	1200	4.4
ACCIDENTS	1150	4.2
DIABETES	600	2.2
ARTERIOSCLEROSIS	480	1.7
OTHER ARTERIAL DISEASES	385	1.4
SUICIDES	310	1.1
ALL OTHER CAUSES	4725	17.2

Cancer occurs in people of all ages, although more than 80 percent of the cases occur in those 55 and older. Among children, leukemia and brain cancer are most common, while lung, colon and rectum, breast, and prostate cancer occur with greatest frequency among older Iowans.

TOP 3 TYPES OF NEW CANCER IN IOWA ESTIMATED FOR 1993: Females & Males by Age Group

	SITE	# OF CASES
Ages 75+	BREAST	675
	COLON & RECTUM	545
	LUNG	200
	PROSTATE	870
	LUNG	465
	COLON & RECTUM	410
Ages 55-74	BREAST	855
	COLON & RECTUM	450
	LUNG	430
	PROSTATE	990
	LUNG	820
	COLON & RECTUM	525
Ages 35-54	BREAST	510
	OVARY	80
	LUNG	75
	LUNG	120
	COLON & RECTUM	85
	SKIN MELANOMA	55
Ages 15-34	BREAST	40
	THYROID	35
	SKIN MELANOMA	30
	TESTIS	45
	SKIN MELANOMA	20
	HODGKIN'S DISEASE	20
Ages Under 15	LEUKEMIA	15
	BRAIN	15
	SOFT TISSUE	5
	LEUKEMIA	15
	BRAIN	15
	NON-HODGKIN'S LYMPH.	5

Fortunately for Iowans, the chances of being diagnosed with many types of cancer can be reduced through positive health practices such as smoking cessation and healthful dietary habits. Early detection through self-examination and regular health check-ups can dramatically improve cancer treatment and survival. During the 1990s preventive measures and early detection should show positive changes in the cancer statistics reported by the registry.

Primary cancer of the head and neck

One hundred and seventy-eight cases of squamous cell carcinoma of the head and neck were reviewed. The incidence of second malignant neoplasms was 15%. The authors conclude that environmental and life-style factors contributed to the development of a second malignancy.

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Des Moines, Iowa

SURGERY HAS BEEN UNIQUELY involved with reported cases of second malignant neoplasms since Billroth stated that some patients can develop a second malignant neoplasm simultaneously and independently of a first malignant neoplasm.[1] Many tumors reported late in the 19th and early in the 20th century were metastatic disease or misclassifications of tumors near the primary.

Billroth suggests second malignant neoplasms should be considered a second malignant neoplasm when a separate organ system is involved and/or the histopathology is different. Clearly, some of the second malignant neoplasms described by Billroth in different organ systems were metastasis to that organ system and others were not.

Furthermore, Billroth observed that a second malignant neoplasm can develop after a first malignant neoplasm has been treated. He was referring to cancers treated surgically in the late 1800s and this has relevance today in light of the known carcinogenic effects of chemotherapy, radiation and environmental factors.

Interest in second malignant neoplasms continued into the 20th century. Warren and Gates reported 1,259 cases from the world literature in 1932.[2] Again in 1953, Watson reviewed 1,171 cases of multiple primaries.[3] Moertel reported in 1961 that more than 10,000 cases of multiple primary malignant cancers had been reported in the literature by several hundred authors.[4] This probably represents the increased awareness by clinicians to look for second malignant neoplasms in their patients. Moertel points out that with modern medicine (surgery, radiation, chemotherapy) second malignant neoplasms can result from therapeutic intervention.

This is seen most recently in the NCI report on the Wilm's Tumor Study in which children successfully treated with chemotherapy and radiation therapy after 10-15 years develop second malignant neoplasms at a rate higher than predicted.[5] Also, the carcinogenic effects of radiation are well known from the work with the atomic bomb survivors and patients receiving

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THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR FEBRUARY 1993

exposure to low dose radiation or to high dose radiation therapy.[6-8]

Recently, the reported incidence rate of second malignant neoplasms for all cancers seems to range from 1% to 3% to 10%.[9-11]

It is helpful to define second malignant neoplasm occurrence relative to time from the diagnosis of first malignant neoplasm. Simultaneous malignancies are discovered at the initial presentation. Synchronous malignancies are discovered any time within six months of each other and include simultaneous malignancies. Tumors discovered beyond the six month interval are referred to as metachronous (Hordijk 1983).[12]

This paper is concerned with squamous cell carcinomas of the head and neck reviewed retrospectively from 1974-1983 at Veterans Administration Medical Center in Des Moines, Iowa. All head and neck cancers were reviewed. All cases with a second malignant neoplasm were reviewed.

Study results

There were 26 cases of a head and neck squamous cell carcinoma which had second malignant neoplasms between 1973-1984. Of these, five cases had an existing second malignant neoplasm at the time the first malignant neoplasm was diagnosed; 22 cases developed a second malignant neoplasm after primary treatment.

The overall incidence of a second malignant neoplasm was 15%. The incidence rate of simultaneous second malignant neoplasm was 3% (5/178) and the incidence rate of a metachronous second malignant neoplasm after treatment was 12% (22/178). Development of a second malignant neoplasm after treatment occurred within a range of 5-113 months.

The most common site of a second malignant neoplasm was lung (8 squamous cell carcinomas and 3 adenocarcinomas), followed by prostate (4 cases of adenocarcinomas), esophagus (2 cases of squamous cell carcinomas), pancreas (2 cases of adenocarcinomas) and trachea (2 cases of squamous cell carcinomas). The remainder of the cases occurred in the bladder, colon, rectum, parotid, epiglottis, base of tongue and nasal cavity. None of the second malignant neoplasms occurring in the head and neck were contiguous to the first malignant neoplasms.

The most common histopathology of second malignant neoplasm was squamous cell carcinoma (16 patients) and adenocarcinoma (11 patients). There was one transitional cell carcinoma of the bladder and one mixed malignant tumor of the parotid. One patient had three simultaneous cancers located in the floor of the mouth, tonsil and nasopharynx. Within 10 months, this patient had developed an adenocarcinoma of the prostate. Three patients had more than one second malignant neoplasm.

The average age of diagnosis of the first malignant neoplasm was 61 years (range 39-79). The average age of diagnosis of the second malignant neoplasm was 63 years (range 45-80). The average duration between first malignant neoplasm and second malignant neoplasm was 32 months (range 5-113 months). The average number of months of survival from the diagnosis of the second malignant neoplasm to death was six months (range 1-47 months).

The most common locations of the first malignant neoplasm were larynx (8), oropharynx (6), floor of the mouth (6), hypopharynx (3), then buccal mucosa, nasopharynx and lip (1 each).

Treatment of the first malignant neoplasm included surgery alone (6), surgery and radiation (5), radiation alone (8) and chemotherapy and radiation (6). For surgery various resections were performed based on the clinical situation. All radiation was given in doses greater than 5000 rads. Chemotherapy included methotrexate and bleomycin, mitomycin and 5-FU, methotrexate, cis-platinum and bleomycin, 5-FU and mithramycin, and 5-FU and DDP.

Simultaneous malignant neoplasms

Five patients had simultaneous second malignant neoplasms. One patient had a squamous cell carcinoma of the floor of the mouth. The second malignant neoplasm was a squamous cell carcinoma of the lungs. Death occurred within two months. Another had three simultaneous neoplasms in the head and neck. The patient died within 10 months having developed an adenocarcinoma of the prostate. One patient had a squamous cell carcinoma of the hypopharynx and a squamous cell carcinoma of the lungs. The patient died within one month during treatment with radiation. Another was a carcinoma in situ at the base of the tongue. The second malignant neoplasm was an adenocarcinoma of the lung. The patient died within two months. Another had squamous cell carci-

noma of the larynx and adenocarcinoma of the colon, and died within two months.

There were 13 patients who smoked, three patients who drank, four patients who smoked and drank and six patients whose records did not indicate if smoking and drinking were risk factors.

High incidence

The small number of patients in this study precludes a statement that the first malignant neoplasm or its treatment dispose the patients to certain second malignant neoplasms. However, the incidence of second malignant neoplasm seems uncommonly high for such a small population.

In this study, the upper aerodigestive tract has been exposed to the carcinogens in tobacco. Alcohol, though not a carcinogen, may enhance the carcinogenic effects of tobacco. The second malignant neoplasms involving the lung, trachea, esophagus, floor of mouth, base of tongue and epiglottis are easy to explain because of the concept of field cancerization; however, second malignant neoplasms involving the prostate, bladder, rectum, colon and parotid are not as easily conceptualized. Would these patients have developed a cancer in the locations of the second malignant neoplasm had no first malignant neoplasm developed? Did chemotherapy contribute to the development of a second malignant neoplasm in these five patients? These are questions that larger case studies may answer.

What is clinically important is the awareness that other tumors can exist synchronously or metachronously with a first malignant neoplasm. For head and neck cancers the role of panendoscopy cannot be over emphasized. Gluckman, Maisel, Vrabec and Grossman clearly show the importance of panendoscopy.[13-16]

Surgeons are intimately involved in the care of the head and neck cancer patient from the early stages of care. The surgeon's awareness that a second malignant primary may exist will benefit the patient. It is also consistent with the teachings of Billroth.

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References are available from the authors or the editors of *IOWA MEDICINE.*

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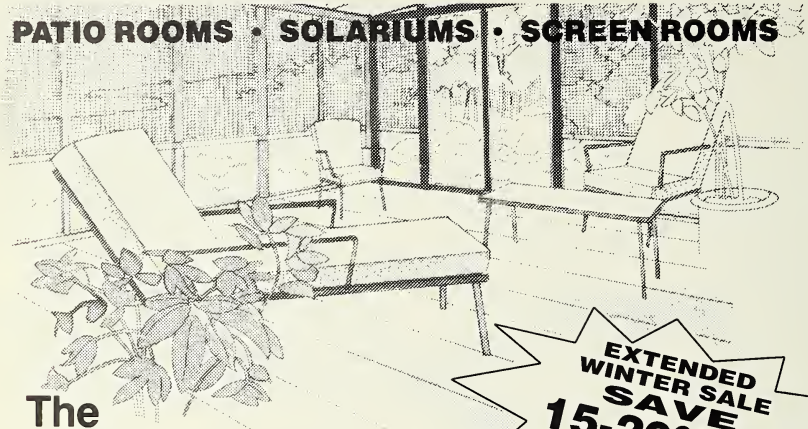
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A patient with 56 primary malignancies

This very unusual case involves a 70-year-old white male who was within 50 miles of atomic bomb testing in the Mohave Desert and had 56 primary malignancies from 1946 to 1992. Major cytogenetic abnormalities sometimes found in patients with apparent genetic susceptibility for developing solid tumors are reviewed.

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Des Moines, Iowa

THIS 70-YEAR-OLD PATIENT has been followed by the Department of Surgery at the VA Medical Center in Des Moines since 1969. Otherwise healthy, he has been surgically treated for numerous basal cell carcinomas of the skin, squamous cell carcinoma of the skin and Duke's B adenocarcinoma of the colon. He reported that he was in the Mohave Desert (Nevada) from 1942-44, within 50 miles of several above-ground atomic bomb explosions. There is a history of repeated contact with fallout material and he believes this exposure may be responsible for his recurrent malignancies.

Apart from neoplasia, his only other medical problem is mild degenerative joint disease affecting his right hip, for which he takes naproxen 375 mg tid prn. He takes no other medications. His non-oncologic surgical history is significant for appendectomy in 1964, hemorrhoidectomy in 1961 and cholecystectomy in 1979 for symptomatic cholelithiasis.

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His family history is extensive. His father died of pancreatic cancer at age 81, his brother had melanoma, his uncle had colon cancer and his grandfather died of squamous cell cancer invading the jugular vein. He denies alcohol use, but has smoked a pack of cigarettes per day for approximately 54 years. He is an alert, well-nourished, elderly white male. Apart from numerous well-healed surgical scars, the physical examination is unremarkable.

Mr. PS's first malignancy was a posterior-auricular basal cell carcinoma of the skin diagnosed in 1946. Subsequently, he has presented with 53 basal cell cancers, each apparently a new primary. His tumors have typically presented as non-healing skin lesions, oftentimes ulcerated or bleeding. Table 1 shows an impressive list of the anatomical sites involved. Of particular note, many have occurred on non-sun-exposed areas. Each time, the lesions have been removed as an excisional biopsy, with negative margins and without local recurrence.

In 1981 Mr. PS was admitted to our hospital for workup of chronic diarrhea with hematochezia. Flexible sigmoidoscopy demonstrated a friable mass lesion at 18 cm, which was found to be well-differentiated adenocarcinoma. He subsequently underwent rectosigmoid colectomy with end-to-end anastomosis and pathological examination revealed Duke's

(Continued next page)

B adenocarcinoma. The margins were negative and the procedure was curative. In 1985, he was found to have a 1 cm × 1 cm squamous cell cancer involving the skin of the face. This was cured by surgical excision.

In June 1992, peripheral blood was obtained from Mr. PS and sent to MetPath laboratories (Teterboro, New Jersey) for investigational chromosomal and cytogenetic analysis. Unfortunately, no pathological specimens of actual tumor were available for study. PHA-stimulated lymphocytes and Giemsa-trypsin stained (G-banded) metaphases showed random loss of chromosomes in 34% of cells (a positive but non-specific finding).[1,2] The remaining cells revealed a normal-appearing 46, XY male chromosome complement. No increased breakage or other abnormalities were observed.

TABLE 1

SKIN LESIONS FOUND TO BE CANCER

Anatomical location	*No. primary lesions excised*
left angle of mandible	2
left neck	3
left posterior auricular region	2
left pre-auricular region	4
left ear	2
left temple	2
left nose	2
left naso-labial groove	1
left forehead	3
left cheek	2
left chin	1
left shoulder	1
left suprasternal notch	1
left shoulder	1
left back	2
left scrotum	1
left perianal region	1
right upper cheek	1
right lower cheek	1
right submandibular region	1
right forehead	3
right zygomatic region	1
right external auditory canal	1
right ear	1
right posterior auricular region	3
right pre-auricular region	2
right concha	1
right neck	2
right nose	1
right sternum	1
right back	2
right axilla	1
right suprapubic region	1
right perianal region	1

Comment

Only three decades have passed since the number of human chromosomes was determined, but great advances have been made in our understanding of genetics and its role in malignant disease. The field of cancer cytogenetics has been growing exponentially: more and more chromosomal abnormalities are being shown to be of importance in carcinogenesis. Indeed, oncogenes and tumor suppressor genes and the consequences of their molecular abberation have contributed greatly to our understanding of cancer.

While the study of hematological malignancies has produced much data, for most solid tumors our knowledge is very rudimentary. A principal reason is that metaphase cells obtained from solid tumors are typically of very low technical quality, hence chromosomal markers cannot be determined with certainty.

TABLE 2

SOLID TUMORS WITH KNOWN CYTOGENETIC ABNORMALITIES (FROM HEIM ET AL)[3]

Type of tumor	*Chromosomal abnormality*	*Freq (%)*
Alveolar rhabdomyosarcoma	translocation 2;13	unknown
Bladder carcinoma	various translocations	20-30
	trisomy 7	10
	monosomy 9	10
Breast carcinoma	trans/del 16q	20
	structural changes of 1	80
Colon carcinoma	structural changes of 1	20
	trisomy 7	30
	trisomy 12	10
	structural changes of 17	unknown
Ewing's sarcoma	translocation 11;22	> 90
Melanoma	trans/del 1	60
	translocation 1;19	unknown
	trans/del 6q	80
	trisomy 7	50
Myxoid liposarcoma	translocation 12;16	unknown
Neuroblastoma	del 1	70
	dmin	70
Ovarian carcinoma	structural changes of 1	80
	translocation 6;14	unknown
Prostatic adenocarcinoma	del 7	unknown
	del 10	unknown
Renal cell carcinoma	trans/del 3	80
	translocation 5;14	unknown
Retinoblastoma	structural changes of 1	50
	inversion 6p	30
	del 13	20
Small cell lung cancer	translocation X;18	> 90
Testicular seminoma	inversion 12p	90
Wilm's tumor	structural changes of 1	50
	trans/del 11	30

In contrast, hematological cells are readily obtained and separated.

Several of the known characteristic karyotypic abnormalities of solid tumors are shown in Table 2.[3] It should be appreciated that many of these malignancies have a very high association with chromosome rearrangements (i.e. > 50%). In many cases, specific cytogenetic abnormalities have been shown to be of prognostic significance, with abnormal karyotypes generally faring worse.[3]

In summary, Mr. PS has been treated for a total of 56 primary cancers and continues to be followed in our clinic. We know of no other patient who has been reported with as many separate, non-metastic malignancies. However, we were unable to demonstrate a known cytogenetic abnormality associated with cancer susceptibility in this patient, which is likely a consequence of our limited understanding of solid neoplasms.

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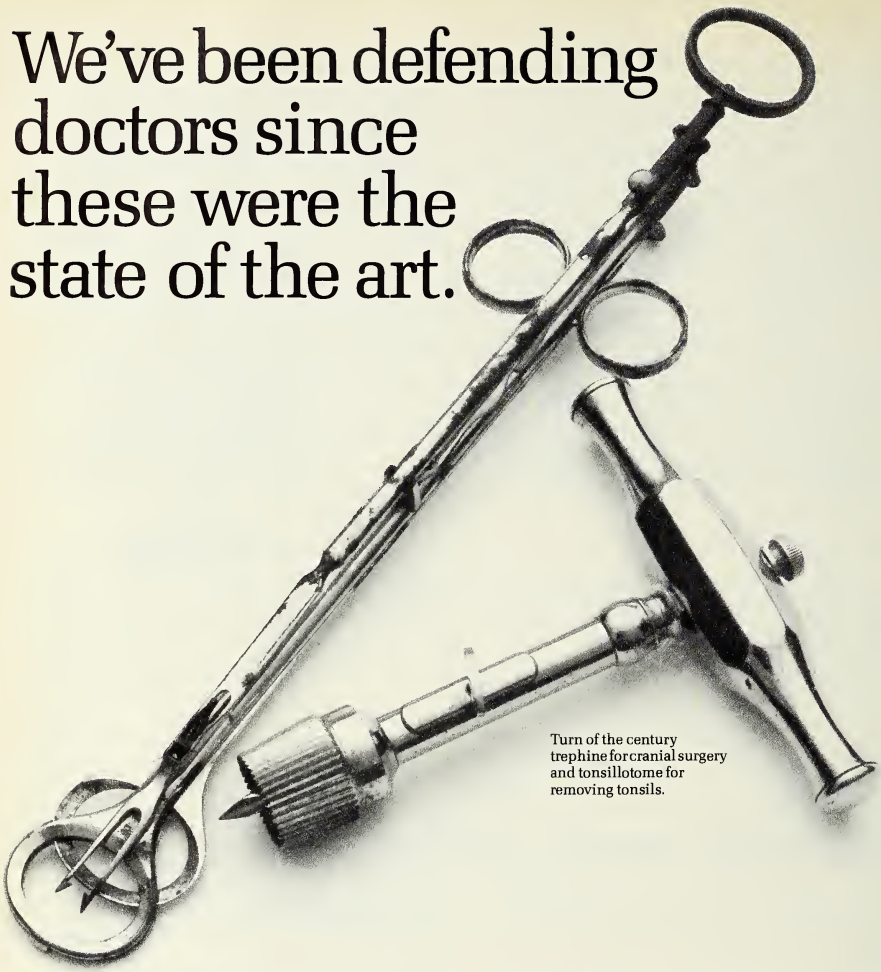
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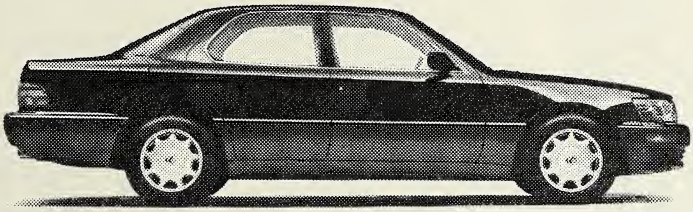
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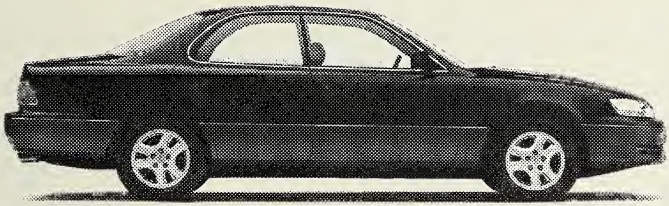
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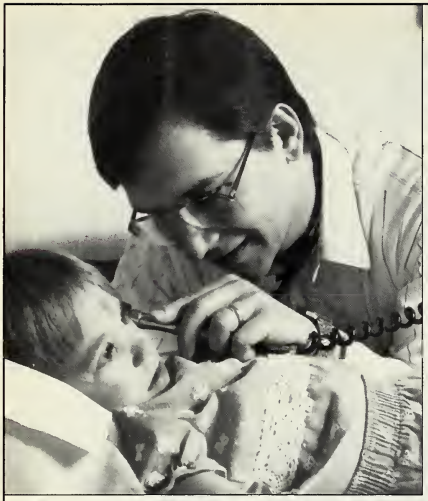
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When to transfer from acute to skilled

On August 7, an 80-year-old female came to her physician's office after she began feeling weak and losing her balance. She hadn't eaten for a couple of days because she choked when she tried to swallow.

The physician noted a great deal of mucous in her mouth. No oropharyngeal lesions were seen; her neck had no adenopathy or thyromegaly. There were clear bilateral breath sounds. The patient was a non-smoker.

The attending physician admitted the patient to the hospital. Laboratory work showed her hemoglobin was 14.1, white count 10,700 with a left shift, the serum albumin was low at 3.2, and the urinalysis was negative. The admitting x-ray was unrevealing. Sputum culture results on August 10 showed gram negative rods which eventually grew pseudomonas aeruginosa.

On August 8, the patient was examined by an ENT surgeon who determined that the patient's swallowing problems resulted from a neuromuscular dysfunction. The ENT surgeon also recommended a feeding gastrostomy if the neuromuscular dysfunction could not be controlled medically.

On August 12, the patient underwent a nasojejunostomy tube insertion. After the procedure, the patient was afebrile, though less oriented. She began receiving antibiotic coverage of Amoxicillin and Ciprofloxacin through the tube. She tolerated the Jevity feedings at 100 cc per hour. Later that day, her sputum became more purulent in color. An x-ray showed a left lower lobe penumonia with bibasilar atelectasis.

The attending physician placed the patient at the skilled level of care on August 13. She was readmitted to acute care one week later, due to a deteriorating respiratory status and decreasing responsiveness.

Reviewer comments

This case was determined to be an inappropriate transfer from acute to skilled level of care. This patient was diagnosed per x-ray to have a dense pneumonia on August 12, with sputum growing pseudomonas. The patient's respiratory status should have been further assessed and the diagnosis of pneumonia resolved prior to the approval of transfer to the skilled unit. This was determined to be a quality concern and was assigned a severity level III which is defined as a quality problem with significant adverse patient effects.

In making your decision to transfer a patient from acute to skilled care, consider:

- Whether the patient's plan of care has recently required significant modifications. If so, has enough time elapsed to allow for an assessment of the success or failure of these modifications?
- Whether the patient continues to require daily physician visits.
- The general stability of the patient's medical condition and whether the patient has received maximum benefit from acute hospitalization.

This article was written by Steven Berry, M.D., a Des Moines pulmonologist and a reviewer for the Iowa Foundation for Medical Care.

Medical informatics and continuing education

Richard Nelson, M.D.

WORDS SUCH AS "INFORMATICS" are alien to the vocabularies of many physicians. Some physicians may find that specific word to be vaguely disturbing, not only related to its unfamiliarity, but also its suggestion of a new scientific technology that challenges learning capacity.

The capacity to learn is a widely discussed topic among educators. In medicine there is a concern about information overload. The perpetual deluge of print materials flowing into the offices of physicians validates the problem. An agency of the federal government recently reported that the quantity of information in a weekday edition of the *New York Times* approximates the amount of information an average seventeenth-century professional was exposed to in a lifetime!

Every physician, intentionally or not, develops a coping strategy for the information glut contained in print materials. Selected periodicals may receive a quick perusal; a few may be read with care. Other publications are ushered onto a shelf or into the waste with nary a glance.

Anecdotally, most physicians express frustration with their inability to maintain fluency with advances in medical care summarized or reported in print. They probably do not view their situations as captive to a single technology, but they are. That technology is physiological optical scanning (reading). The material scanned is whatever presents itself in the mail. Even when information of interest is identified through reading, the retention of that information (its topical organization, filing and retrieval) is an overpowering chore to all but the most compulsive physician.

In this context, the discipline of medical informatics is emerging. The discipline is somewhat amorphous in dimension, but it encompasses many approaches utilized in computer-assisted organization and retrieval of information.

An increasingly computer-literate generation of physicians are graduating from the nation's medical schools. That literacy is a curious derivative of childhood experience with computer-board games, school classroom exercises with simple databases and word processing, and subsequent collegiate and medical school use of computers for a wide variety of functions.

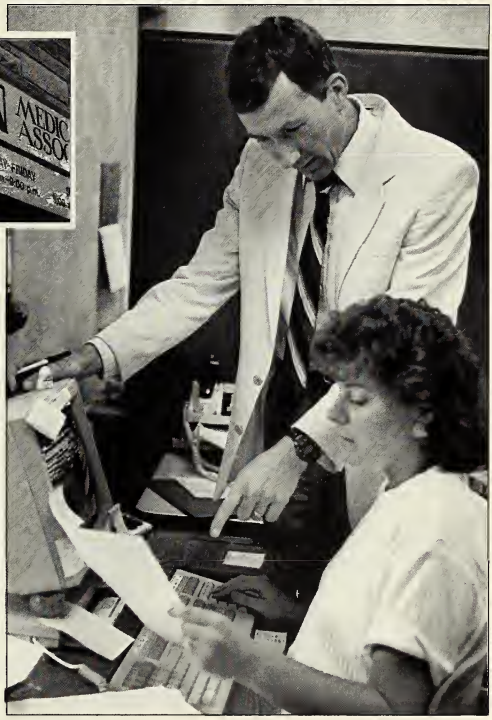
While the teaching of information technologies in American medical schools appears to be lagging behind current clinical applications in medicine, one recent development is of special relevance to continuing education. With rapidly increasing frequency, the faculty of medical schools are participating in development of educational software in the basic and the clinical sciences. The pace of development of such software has accelerated to the point at our College of Medicine at the University of Iowa that we need to inventory current products to assure that faculty and students throughout the college are aware of their existence.

Many of these educational programs are as useful to the practicing physician as they are to the medical student. The only eventual barrier to their application in continuing education is the interest of physicians in using the software. The rapidly expanding use of computers in medical offices for business purposes has placed the necessary hardware within steps of the large majority of community doctors.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

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William Eversmann, Jr., M.D.

Managed competition

IT IS CALLED MANAGED competition but it has no uniform definition. President Clinton has been said to favor this type of health care reform.

Enthoven suggested the managed competition model in 1978 and co-authored later manuscripts with Richard Kronick, a consultant for the Iowa Leadership Consortium. The Jackson Hole group defined the model which consists of sponsors (employers, government agencies and labor) who would purchase health insurance through purchasing groups. The sponsors would set the amount paid for health insurance for individuals they represent and would contribute an amount equal to the lowest cost coverage for basic benefits. Additional benefits could be purchased by the employee but not at the expense of the employer or purchasing group.

Simply stated, big business, government and labor combine their economic strength to control the costs of competing managed care organizations including HMOs, hospitals with dedicated medical staffs or insurance companies.

The offices of physicians dedicated to managed care organizations are full of patients because these physicians offer the lowest cost care to those sponsored by big business.

The highest cost providers not working under managed care organizations and therefore not treating patients sponsored by big business, care for employees of smaller companies, the unemployed and Medicaid and Medicare patients, some of whom will buy the higher cost policies.

Managed competition then becomes the **new cost shifting.**

The combination of managed competition and selective contracting produces the most notable degree of cost shifting. When hospitals become involved, so does the cost shifting of economic credentialling.

Richard Kronick recently said that managed competition can work only in metropolitan areas. (By his definition, Iowa's metropolitan areas are Des Moines and Council Bluffs-Omaha.) What he has not said is that the managed competition model manipulated further by selective contracting, economic credentialling of physicians and even contracts with health care providers outside Iowa can lead to the destruction of Iowa's health care delivery system. It is certain that rural Iowa will feel the greatest impact first and that the long suffering parameters of access and quality of health care will be ignored.

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The Throckmorton Surgical Society and Iowa Academy of Surgery Spring Meetings

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Friday, April 30, 1993: The Throckmorton Surgical Society Symposium on Breast Cancer

Guest Faculty

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St. Joseph's Hospital Cancer Center
St. Louis, Missouri

Blake Cady, M.D.
Professor of Surgery
Harvard Medical School
Chief of Surgical Oncology
New England Deaconess Hospital
Boston, Massachusetts

Frank E. Gump, M.D.
Chief, Surgical Service
Department of Veterans Affairs
Professor of Surgery
UMDNJ/New Jersey Medical School
East Orange, New Jersey

Peter R. Jochimsen, M.D.
Professor, Surgery
University of Iowa College of Medicine
Director, Surgical Oncology
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Karl G. Kardinal, M.D.
Ochner Clinic
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General Surgeon
Centreville, Mississippi

Topics

- *Postmastectomy Irridation: What is Its Role Today?*
- *Limitations of Mammographic Screening*
- *Breast Conservation Surgery: Patient Selection*
- *Treatment of Noninvasive Breast Cancer*
- *Contemporary Therapy of Early Breast Cancer*
- *Management of the High Risk Breast Patient*
- *Tamoxifen Breast Cancer Prevention Trial*
- *Pitfalls of Needle Localization and Sterotactic Techniques*
- *Rationale for and Status of the NSABP Prevention Trial*
- *Management of Locally Advanced and Inflammatory Breast Cancer*
- *Update on Adjuvant Therapy of Breast Cancer*
- *Surgery in Rural America*

Saturday, May 1, 1993: Iowa Academy of Surgery Meeting

Speakers

William W. Eversmann, Jr., M.D.
President, Iowa Medical Society
Orthopedic Surgeon
Cedar Rapids, Iowa

Roger D. Tracy
Assistant to the Dean/Director,
Office of Community-Based Programs
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Daniel K. Zismer, Ph.D.
Principal, Director and Co-Founder
of Partners Consulting Group, Ltd.
Minneapolis, Minnesota

Topics

- *Presentation of Resident Competition Papers and Awards at the Scientific and Clinical Session*
- *The Future of Health Care Reform in Iowa: Where is Iowa Going?*
- *The Future of Rural Medical Care in Iowa*
- *Hospital-Physician Relationship in the '90s*
- *Panel Discussion: Where is the Solo Physician Going? Crystal Ball Predictions*

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Want to just be a doctor? Try locum tenens

Locum tenens is an exciting opportunity for those who have had enough paperwork and weekend work and want to worry only about patient care, says this former IMS president who retired several years ago from his Spirit Lake family practice.

Donald Rodawig, M.D.
Spirit Lake, Iowa

THE PRACTICE OF MEDICINE is alive and well in spite of criticism to the contrary. Caring for patients is still the most satisfying aspect of being a family doctor.

I have been blessed by being able to live, grow up and practice in a great area in rural Iowa. Last year I retired from the medical center where I began practice 35 years ago. I was fortunate to work with my father who began practice there in 1931. There had been a Rodawig practicing here for 60 years when I decided to retire.

I was surprised when my father retired to a student health position in Arizona in 1969. One of his reasons was that he found it hard to care for his long time patients and friends. It was difficult for me to understand his feelings then and I was sorry to see him leave our practice.

In the last few years, I began to experience what must have been his feelings. After 35 years, many of my patients were experiencing serious and often terminal illnesses. Every week I found myself counseling the bereaved or attending a funeral. This took a toll on my psyche.

I was tired of always being structured and trying to meet all the deadlines. The government intrusions and paper hassles made patient care more difficult.

Free at last

Our children were raised and educated. My wife and I were free to go anywhere we pleased so I retired from my practice. What a deal! I could play golf when I wanted, go to coffee or have lunch with the boys, go to ball games on the weekends and enjoy the lake and all those activities I did not or thought I did not have the time to do. At last I could live like many of my friends seemed to do.

After a couple of months of this unstructured life, I felt something was lacking. I missed patient contact and felt bored with my life. I guess I had been on the firing line too long. I thought it would be unfair to my new associate to return to practice part-time. Most of my patients were seeing him or one of my former partners. I needed to let this happen. The best answer seemed for me to be away from my home for a time so the adjustment would occur.

I began looking into locum tenens organizations. The company I chose was started initially to set up and staff rural health clinics.

(Continued next page)

Today they have developed a network of physicians who replace doctors for a myriad of reasons including vacations, CME, illness, loss of provider in a community, introduction of a new facility or as a stop gap measure while they recruit a permanent associate.

They help their members with a choice of locations, licenses, provide malpractice coverage, transportation, housing and give a competitive remuneration.

Barraged with calls

We decided to try short term assignments in the Carolinas in the spring and fall, Arizona in the winter months and, of course, Okoboji in the summer or between assignments. Since

'I felt something was lacking. I missed patient contact and felt bored with my life. I guess I had been on the firing line too long.'

I sent out my resume, I have been barraged with calls offering me all sorts of jobs in family medicine. I can accept or turn down any or all potential assignments. We make our plans and work our locum tenens jobs in between. My choice of assignment is office based family medicine without hospital or call duties. This leaves my nights and weekends free. This kind of practice has been rewarding, challenging and interesting.

The upside of locum tenens work:

- I'm back caring for patients without peer review, personnel and collection problems.
- When my scheduled time is finished, I can go home.
- My assignments are negotiable. If the job or the location is not appealing, I turn it down.
- After each assignment, mutual performance assessments are done. In that way the company can know the extent of physician and client satisfaction.
- We meet all kinds of people, which is exciting. Variety is the spice of life! Ninety-five percent of the patients I saw were respectful and thankful for their care. Their accents and color were different, but they were nice.

AMA has locum tenens service

The American Medical Association has available a Locum Tenens Service for physicians looking for short term positions and for practices recruiting temporary replacements. The Service provides the widest possible exposure through listing locum tenens positions in AMA's Opportunity Placement Register and through presenting abbreviated curricula vitae of physicians in the register.

For more information about the service, call the AMA, 1/800-955-3565.

- I have renewed my enthusiasm for medicine.

Back to basics

In one southwestern Arizona clinic most of my patients were Mexican who spoke little or no English. Even though I had interpreters, I needed to revert to basic physical diagnosis that was stressed in medical school. Looking at the patient, listening to the patient, auscultation, palpation, interpreting gestures and facial expressions. How exciting and challenging! Most patients were older and were brought in by their children or grandchildren. It was wonderful to see the respect and love they had for their elders. You talk about family values, now there is a real life example!

The downside:

- I have never worked for anyone. I've always been the "boss." Sometimes conditions were less than optimal. Rather than changing them we worked within the situation. This was frustrating but, since it was temporary, I was able to tolerate the condition. I'm learning adaptability. Believe me — good medicine is practiced in Iowa.
- Working in HMOs is an experience! Ordering a CT and having to wait a week for "the committee" to approve it was frustrating for me and the patient. I'm afraid we will have to get used to this in the coming years.
- Being accustomed to prescribing a particular medicine for a specific condition and being told to chose from a list of generic names I've never known is rather trying to

say the least. Again, tolerance and adaptability are required!

- For years I've been waiting to get into the social security public trough. When I received my first check, I framed a copy before I cashed it. Then they told me I'm making too much money to receive it. I guess I'll have to change my lifestyle and try to live to age 70. How boring!
- Taking Grandma away from a nice new retirement home in Okoboji, away from our grandkids, church, bridge Mah Jong and tennis, parking her in an apartment in Glendale, Arizona while I go to an office for an assignment. Now that's a challenging piece of work! This is where the art of compromise takes over, e.g., put the golf clubs away and take her tramping through the Metro Mall Shopping Center on the weekends instead of the lush green fairways of the country clubs.

In the big picture, a blend of retirement coupled with a reasonable amount of work and new experiences seems to be good for both of us at this stage of our lives.



"Ron's Rule—I give myself one week to meet new people and start having fun on a locum tenens assignment. It hasn't failed me yet."

Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

A singer. A board-certified family practitioner. Soft-spoken for a New Yorker. Ron Richmond knows...

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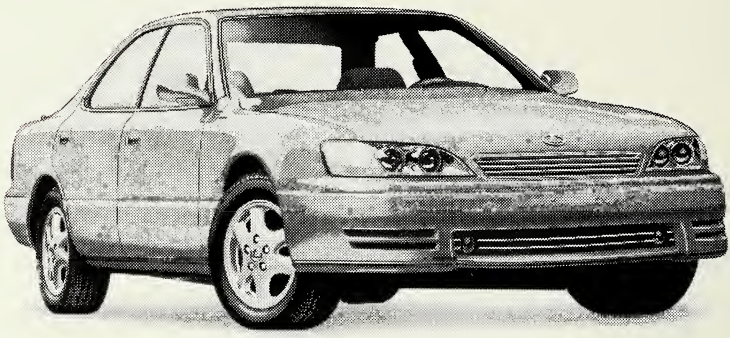
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Timothy Hart, M.D.

Heart disease and Iowa's high school athletes

How many of Iowa's high school athletes are competing with undiagnosed heart disease? This Des Moines internist and some of his colleagues decided to find out.

Please tell us about your study of athletes and heart disease. What was its purpose?

My colleagues and I were concerned that some Iowa high school athletes could be playing with unrecognized heart disease. In the past, the media have focused on cases involving athletes in seemingly excellent condition and at the peak of their careers who develop manifestations from previously unrecognized heart disease. Obviously, these problems are usually recognized too late and we became curious about whether current technology can identify high risk athletes.

A review of the literature told us we needed to consider the types of heart disease to be screened and the prevalence of each type of heart disease. It became apparent that history and physical alone cannot adequately identify those seemingly at high risk for cardiac collapse. Even doing EKGs and chest x-rays on every athlete could not identify those at high risk.

Consequently, we identified a population of central Iowa high school athletes at risk and performed an EKG and echo Doppler color flow examination on each of them. We believed this method might help reveal the exact incidence of serious heart disease in this population and demonstrate the effectiveness of these tests for these individuals. This has now evolved into a national project which has involved performing the same evaluations on high school athletes at eight sites across the country.

What are the major findings from your study?

The initial study of 500 high school athletes found some recognizable echocardiographic abnormality in about 3% of athletes. One percent of these required further testing with cardiac angiography and catheterization. Two atrial septal defects were identified, one of

(Continued next page)

which required surgical repair. One coronary anomaly was found by the color flow Doppler.

We were surprised by the relatively high frequency of abnormal echo Dopplers in this population. However, all athletes subsequently returned to the playing field since a majority of the abnormal findings were minor abnormalities. We were equally surprised we found no cases of hypertrophic heart disease, congenital aortic stenosis or problems of the aortic root in this study population. The second year of this study involved 900 students and revealed several abnormalities that will probably require surgery.

Are physical examinations currently given to high school athletes adequate to find potential problems?

Our intention is not to criticize the high school physical and history as a screening tool for young athletes. We believe it serves its purpose quite well. However, a history and physical are not sensitive or specific enough to identify high risk cardiac conditions. The results of this study do not indicate every Iowa high school student preparing for athletics should undergo echo Doppler and EKG evaluation. Sudden death of high school students during sporting events occurs at a frequency of 0.4 cases per 100,000 participants. Our main objective was to use these screening tests to identify at least two-thirds of the high risk athletes.

Is athletic competition in Iowa safe for high school students? Are proper precautions taken for possible problems?

The answer is a resounding yes. Athletics is very safe for high school students. The frequency of undetected catastrophic cardiac abnormality is extremely low. Though there is a low but detectable frequency of congenital heart abnormalities in this high school population, most of these do not change a student's playing status. There appears about one out of 200 high school athletes have an unrecognized reparable congenital heart problem. During the 1960s through the 1980s, significant training advancements and improvements in equipment made the environment safer for every high school athlete.

I believe athletics in Iowa is very safe but this trial was undertaken to determine if we can make athletics even safer.

Beef Industry provides free nutrition materials

THE IOWA BEEF INDUSTRY COUNCIL is providing free informational booklets to physicians for their patients and professional office staff. The booklets, published by the National Livestock and Meat Board, are free of charge and may be ordered in quantities.

Written materials geared toward health professionals include "Nutrition Strategies: A Physician's Guide" and "Food in Focus: A Nurse's Guide to Nutrition."

Patient education materials include "Nutrition Strategies . . . Designs for Heart-Healthy Living," "Sterling Advice for the Silver Years," "Nutrition During Pregnancy" and "A Food Guide for the First Five Years." Meat specific information is also available upon request.

To obtain any of these free resources, the "Health Professionals Resource Catalog" or for information on other nutritional materials, contact the Iowa Beef Industry Council, P.O. Box 451, Ames, Iowa 50010; phone 515/232-0428; fax 515/233-5531.

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Today, beef cuts are lower in fat

According to a national supermarket survey, there is on average 27% less trimmable fat on retail beef today than in the late '70s and early '80s.[1] A follow-up survey in 1990 confirms a continued reduction in fat trim.[2]

AHA and NCEP guidelines allow lean beef

The American Heart Association and the National Cholesterol Education Program have recognized the place for lean beef in a varied, balanced diet. Both of their dietary guidelines recommend up to 6 oz daily of lean beef and meats, poultry, or seafood.[3,4]

Here are guidelines that can help your patients enjoy beef that's compatible with a heart-healthy diet:

- Purchase lean cuts
- Keep portions moderate (3 oz cooked)
- Remove visible fat before cooking
- Prepare without additional fat

References:

1. Savell JW, et al. National Beef Market Basket Survey. *J Anim Sci.* In press.
2. Morgan JB, et al. *National Beef Tenderness Survey: Meat Research Brief.* College Station, Tex: Meats and Muscle Biology Section, Department of Animal Science, Texas A & M University; 1990.
3. American Heart Association. *Dietary Guidelines for Healthy American Adults.* (Document No. 71-1003). *Circulation.* 1988; 77 (3).
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Cardiovascular disease: treatment and referral

New drugs have brought about a marked improvement in treatment of unstable coronary syndromes.

David Gordon, M.D.
Des Moines, Iowa

FOR THOSE CONCERNED about cardiovascular disease, there is good news and bad news.

Though deaths from cardiovascular disease have declined about 24% in the past decade, coronary heart disease remains the most frequent cause of mortality in the U.S., accounting for nearly 44% of all deaths in 1989.[1] The American Heart Association estimates the cost of cardiovascular disease in 1992 was $109 billion.

Because coronary artery disease is so common, it is important for Iowa physicians to keep abreast of the latest developments in diagnosis and treatment.

It has been well established that patients presenting early with an acute myocardial infarction (MI) would benefit from acute revascularization by thrombolysis, direct percutaneous transluminal coronary angioplasty (PTCA) or bypass surgery.[2-6] The earliest studies demonstrating the benefit of reperfusion therapy by means of bypass surgery were simultaneously reported in Des Moines and Spokane.[7,8]

Despite the multitude of reports extolling the benefits of reperfusion therapy, many probable candidates for revascularization therapy fail to receive it because of concerns of the treating physician.[9,10] In the U.S. today, less than 20% of patients are receiving some type of revascularization therapy. It is estimated that a much higher percentage are potential candidates for reperfusion. This reluctance is more prevalent in the U.S. than in Europe and the reasons for it may include concerns about strokes in elderly patients or patients seeking medical attention after 6 hours despite continuing symptoms.

Recent studies show there may be a beneficial effect of late thrombolysis in the 6 to 12 hour time period after onset of symptoms of an acute MI.[11] Although elderly patients are more vulnerable to a hemorrhagic stroke after thrombolysis without reperfusion therapy they are at a much higher risk for dying after an MI.[12] Thrombolytic therapy is sometimes withheld from acute MI patients who are considered low risk for future morbid events, such as in inferior MI. Normally, acute inferior MI is

Dr. Gordon is an internist with special emphasis on cardiovascular diseases. He practices at the Iowa Heart Center in Des Moines.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR MARCH 1993

associated with low in-hospital mortality. However, if there are concomitant "reciprocal" ST segment depressions for 24 hours or more, there is an increased risk of mortality and complications.[13]

Subject of debate

The mechanism of benefit after thrombolytic therapy following an acute MI has been a subject of some debate. In acute studies in which the thrombolytic agent has been given very early, there appears to be significant myocardial salvage.[14] For most patients, however, mechanisms other than myocardial salvage appear to be present.

Thus, despite a lack of improvement in ejection fraction, an open artery may be beneficial by providing a source of collaterals to other areas of myocardium which may be ischemic. Reperfusion might also improve electrical stability, decreasing the incidence of ventricular arrhythmias. Left ventricular remodeling and enlargement (a risk factor for subsequent poor prognosis) may somehow be inhibited by reperfusion of the infarct zone. Hibernating or severely ischemic myocardium, despite giving the appearance of scar on imaging studies, may prove to be viable with reversible wall motion abnormalities upon reperfusion.

Therapy after an acute MI should include aspirin and heparin.[15] The route of heparin therapy or its duration continues to be debated, with many cardiologists using it from 12-72 hours. In the U.S. it is given intravenously; in Europe it is often used subcutaneously. The benefits of using it in combination with alteplase (t-PA) seem established, but the evidence is less convincing for its use in combination with streptokinase or anistreplase (APSAC).[16]

β-blockers are often given to patients with acute MI and have been associated with an improved prognosis.[17] More than 18,000 patients have been studied and 12 of 15 long-term trials have shown benefit.[18] When all the 15 trials are combined there was a 20-35% reduction in mortality, recurrent MI and sudden death. The mechanism of benefit of beta blockers has been thought to be anti-arrhythmic. Other beneficial mechanisms may be through their anti-ischemic effects, possibly in decreasing plaque rupture or fissuring through reduced blood pressure and a favorable effect on the renin angiotensin system. In the APSI (Acebutolol et Prevention Secondaire de l'Infarctus) trial, acebutolol, a beta selective blocking agent with mild intrinsic sympathomimetic activity, demonstrated a 48% decrease in mortality and a 58% decrease in vascular mortality.[19] Thus, it appears patients with a moderately severe MI may benefit from beta blocker therapy with partial agonistic activity.

Recently, angiotensin converting enzyme (ACE) inhibitor therapy has been used for acute MI. In the SAVE (Survival and Ventricular Enlargement) study, captopril was associated with an improved prognosis in patients with acute MI and an ejection fraction less than 40% during the 2-4 year follow-up period.[20] There was significant reduction of mortality and morbid events and less remodeling of the left ventricle with smaller chambers in the active treatment group.

Complication and follow-up

Modern therapy has reduced complications of MI. Thrombolysis is associated with an increased risk of cardiac rupture often in the first 24 hours.[21] Beta blockers may tend to ameliorate this problem to some extent. Complications of MI which should prompt immediate referral to a cardiac facility are development of acute ischemic mitral regurgitation and acute rupture of the ventricular septum. These conditions often cause a new systolic murmur. They may be diagnosed with either a Swan-Ganz catheter or with an echo Doppler study. Left untreated, these conditions can cause poor prognosis or death.[22]

Coronary angiography is not always indicated in patients with good left ventricular function, especially if there is no evidence of ischemia.[23,24] Unfortunately, a low level treadmill test does not provide enough evidence against ischemia.[25] Because of its relatively low sensitivity, a routine treadmill test may not be as accurate as desired in diagnosing myocardial ischemia.[26] More rigorous testing such as a Thallium treadmill or Stress Echocardiogram taken to at least 85% of predicted maximum would better determine which asymptomatic patients should be referred to a cardiac facility for angiography.

One approach might be to have the patient perform a low level treadmill before discharge and repeat a maximal or sub maximal treadmill test (at least 85% of the maximal capacity) with nuclear or echo imaging. If either the low level or (sub) maximal tests are positive for ischemia, the patient may be a candidate for coronary

angiography. In certain patients, angiography may promote risk stratification.

In otherwise healthy patients with non-q wave myocardial infarction, there is less controversy as to whether they should have angiography. Most experts opt for relatively early coronary visualization. Compared with q-wave MI, there is a far greater incidence of subsequent events (MI, sudden death, etc.) in the first year after the initial event. The in-hospital mortality of q-wave MI is significantly greater than a non-q MI, but the rate is similar for the two types of infarctions in the first year when one adds the subsequent events to the initial one.[27]

After stabilization, the non-q MI patient undergoes angiography and, if necessary, revascularization with PTCA or bypass surgery. Appropriate medical therapy often consists of aspirin, heparin and nitrates. Whereas β-blockers are useful in a transmural MI, some authorities have questioned their usefulness in reducing subsequent mortality or events in non-q MI. Diltiazem, the calcium channel blocker, has a beneficial effect in non-q MI with normal left ventricular function, but not in patients with impaired function of the left ventricle, especially in those patients with pulmonary rales.[28,29]

Coronary lesions

The natural history of coronary lesions is quite variable. Although severe coronary artery stenoses progress to complete occlusion more frequently than do less severe lesions, they oftentimes do not result in infarction.[30] However, a high percentage of patients have infarctions with hemodynamically insignificant coronary lesions on paired coronary angiograms before and after MI.[31] It is postulated that small lipid rich plaques may become fissured or rupture, leading to an unstable coronary syndrome or infarction. The protocol in unstable angina often includes "cooling off the patient" with aspirin, heparin, beta blockers and coronary vasodilators from 2-5 days then coronary angiography and coronary revascularization with PTCA or surgery, if appropriate.

There has been a marked improvement in treatment of the unstable coronary syndromes, but much remains to be done. New drugs which block various platelet functions and early coagulation or enhance thrombolysis may improve the outlook even further.

References

References noted are available from the author or the editors of *IOWA MEDICINE*.

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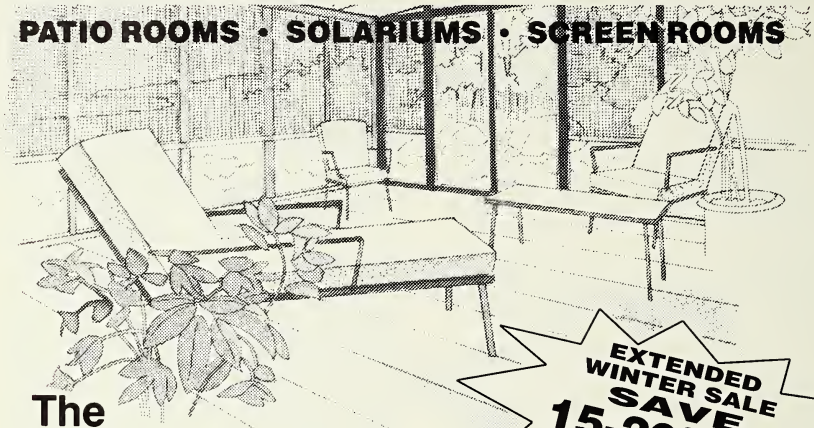
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Intussusception presenting as encephalopathy

Intussusception is one of the most common causes of bowel obstruction from ages three months to five years. The authors describe an eight-month-old who presented with encephalopathy associated with intussusception.

Gregory Hoisington, D.O.
William Bartlett, D.O.
Thomas Kelly, M.D.
Des Moines, Iowa

INTUSSUSCEPTION HAS BEEN DESCRIBED as having a classic presentation. The usual scenario is a child between three months and five years (peak age seven months), previously well, who experiences a sudden onset of severe abdominal pain displayed by a scream, doubling over and drawing the legs to the abdomen. Many vomit or pass a normal to loose stool. Usually after 15-20 minutes the symptoms resolve and the child appears well until the next episode.

As these paroxsysms of pain continue the child becomes lethargic and may have recurrent vomiting and diarrhea. Finally, a "current jelly stool" may be passed. There is a male to female ratio of 3:2 over one year of age.[1,6,11] In the following case of intussusception, encephalopathy was the presenting symptom.

The case

The patient, an eight-month-old white female, was in good health the day prior to presentation and was eating normally. She fell asleep at approximately 11:30 p.m. and awoke at 6:00 a.m. Fifteen minutes later she was noted to be "gaggy," had a brown-tinged emesis and became lethargic without fever. She was taken to the emergency room in the local hospital and was noted to be very somnolent but arousable to stimuli. She was transferred to Raymond Blank Memorial Hospital for Children for further evaluation.

Upon arrival, her heart rate was 200, respiratory rate was 42 and temperature was 98.8°F rectally. Initial examination revealed a well nourished, well developed white female infant who was somnolent but arousable to painful stimuli. When stimulated she became very irritable, then returned to her previous somnolent state. Findings on physical examination revealed pupils to be approximately 2 mm and reactive to light; the fundi were normal. Respirations were increased and shallow without labor.

Abdomen was soft with normal bowel sounds and no masses. Rectal examination was not performed in the ER. She had decreased muscle tone when asleep, but when aroused tone was normal. Neurologic examination showed deep tendon reflexes to be intact and symmetrical, cranial nerves intact. No focal neurologic findings were demonstrated. Diagnosis was encephalopathy of unknown etiology, with a differential diagnosis including Reye's Syndrome, ingestion of foreign substance, or gastrointestinal hemorrhage.

The hemoglobin was 10.6 gm/dl and hematocrit 30.1%. White blood count was 9,400/

(Continued next page)

At the time this article was written, the authors practiced pediatrics in Des Moines. Dr. Hoisington now practices in Bremerton, Washington. Dr. Kelly specializes in child neurology.

mm^3, with 7,800/mm^3 neutrophils, 1,200/mm^3 lymphocytes, and 400/mm^3 monocytes; platelets were 345,000/mm^3. Urine was clear with a specific gravity of 1.021, and 2+ ketones. Arterial blood gases demonstrated a pH 7.359, PaCO2 28, PaO2 266, O2 saturation 99.6%, HCO3 16, and a base excess of −7.4 on 6 L of O2 by mask. Other data included serum sodium 133, potassium 4.6, chloride 103, CO2 19, BUN 10, glucose 101, creatinine 0.1, ammonia 50, and SGOT 47. Drug screen was negative. Cerebrospinal fluid analysis revealed no cells, glucose 56, protein 17, and a negative gram stain.

Further history revealed on one occasion she was noted to pull her legs into her abdomen as if in pain. The surgeon consultant noted a soft "sausage-shaped" mass in the mid epigastric region. Otherwise the abdominal examination was benign. A stool specimen was heme-positive. At this point the intussusception was suspected. A hydrostatic barium enema demonstrated an intussusception of the colon in the region of the splenic flexure. This was reduced to the region of the cecum, but complete reduction was not achieved.

A second enema using an occluding Foley catheter and balloon in the rectum showed the intussusception extending to the region of the ileocecal valve but it could not be completely reduced and the terminal ileum was never visualized. Under general anesthesia, an ileo-colic intussusception was reduced. The patient made a rapid recovery and was discharged on the second postoperative day.

Discussion

Intussusception with classic presentation is easily diagnosed. There have been several reports with Central Nervous System (CNS) depression as a presenting sign.[1,2,4-10,13] Many investigators did not initially diagnose intussusception due to the atypical presentation of altered sensorium. Evaluation of other causes of CNS depression were performed, which involved testing for sepsis, CNS infection, increased intracranial pressure, toxic exposure, hypoglycemia, fluid and electrolyte disorders, and hypoxia.

In a majority of patients, vomiting and a change in consciousness are the presenting complaints. Many of the reports note a progressive lethargy. The majority of patients were hypnotic and responsive only to painful stimuli. Many aroused with vigorous stimulation but when the stimulation stopped they returned to their obtunded state. None of the patients had focal neurologic signs. Three of the reviewed papers note the pupils to be small or pinpoint.[1,4,9]

Naloxone was given to four of 19 patients who had myosis. Two of the four showed transient response to naloxone. A larger dose of naloxone was given in the two that did have responses. There is debate whether naloxone was of benefit.[1,4,8,9]

Initially abdominal palpation for mass was positive in three of 19 patients. This probably related to the early course of disease in which the intussusception was intermittent. Of the 19 cases, 16 were tested for occult blood and nine were positive. This ranged from bright red blood to occult heme-positive stool.

The altered consciousness was usually the primary presenting sign, with only vague symptoms of abdominal pain. There was no reported history of recurrent intermittent abdominal pain. As with our case, after further questioning the parents gave some history of abdominal pain, which was not intermittent and happened only once after the initial vomiting episode.

Multiple theories

There are multiple theories to explain the altered consciousness early in the course of intussusception. Alertness is usually restored following surgical reduction of the intussusception.[1] The pathogenesis of this altered consciousness (encephalopathy) is not known but is considered not to be attributed to hypovolemia, septicemia or electrolyte imbalance.

One theory is that the patient is affected by toxic metabolites released from compromised bowel.[14] Pathophysiology involves the mesentery being compressed and the venous return impaired. Resultant swelling and engorgement cause arterial compression and ischemia of the bowel. The resultant mucosal ischemia releases blood and mucus producing a "current jelly stool." Ultimately bowel necrosis and perforation occur and, without treatment, death.[6]

It is presumed that early in the disease process no compromise of the bowel wall is encountered. It is felt that the altered consciousness due to compromised intestinal mucosal barrier correlates directly with the duration of the symptoms and the degree of bowel viability. Early cases of altered CNS function

were noted in moribund children with a combination of electrolyte and fluid imbalance, blood loss and compromised intestinal mucosal barrier.[7] Toxic metabolic products are postulated to migrate transmurally through obstructed bowel loops with compromised vascular supply causing systemic effects and death.[14] However, the toxic metabolic products have not been defined.

Mucosal barrier integrity is thought to be disrupted in intussusception through a combination of bacterial proliferation and tissue autolysis. The devitalized bowel segment may then lead to a depressed sensorium, especially when there are concurrent profound changes in the systemic vascular system and effective plasma volume resulting in inadequate cerebral perfusion. It is difficult to support an explanation of altered sensorium at the initiation of intussusception when the mucosal barrier has not been altered and hemodynamic changes have not become significant.[7]

Another theory proposed by Tenenbein and Wiseman suggests the possibility that an

(Continued next page)

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early paroxysm of pain may cause a massive release of endorphins which would account for the cortical depression, myosis, hypotonia, hyporeflexia and the apparent response to naloxone observed in their patient.[9] The intestinal tract can release various peptides known to have potent effects on the brain. This interaction of the gut and brain through these mediators is currently being explored.[1] At this time there is no direct evidence that these are the cause of intussusception encephalopathy.

Goetting et al describe the level of consciousness fluctuating spontaneously; therefore, the response to naloxone cannot be described as cause and effect.[1] Tenenbein and Wiseman felt that the earlier attempts with naloxone administration were subtherapeutic for opiate poisoning.[9] Our patient had myosis, which was unexplainable, though naloxone was not given during her hospitalization. The cause of altered consciousness so early in the course of intussusception remains a mystery.

Conclusion

Intussusception is the most frequent cause of bowel obstruction in infants and children aged three months to five years. If the diagnosis of intussusception is missed, bowel necrosis, perforation and death can ensue. The classic presentation of an infant or child with intussusception includes abdominal pain, "current jelly stools," rectal bleeding, vomiting and abdominal mass. These manifestations are not always present. An altered state of consciousness in a previously healthy infant should cause the clinician to consider the possibility of intussusception.

In our case, encephalopathy was the presenting symptom. It is evident that intussusception must be included in the differential diagnosis of altered consciousness. Patients presenting with undiagnosed lethargy or coma should have a rectal examination and stool should be tested for occult blood, plus radiographs of the abdomen. If one is suspicious of intussusception a hydrostatic or pneumatic enema should be performed, both to confirm the diagnosis and to treat the condition.

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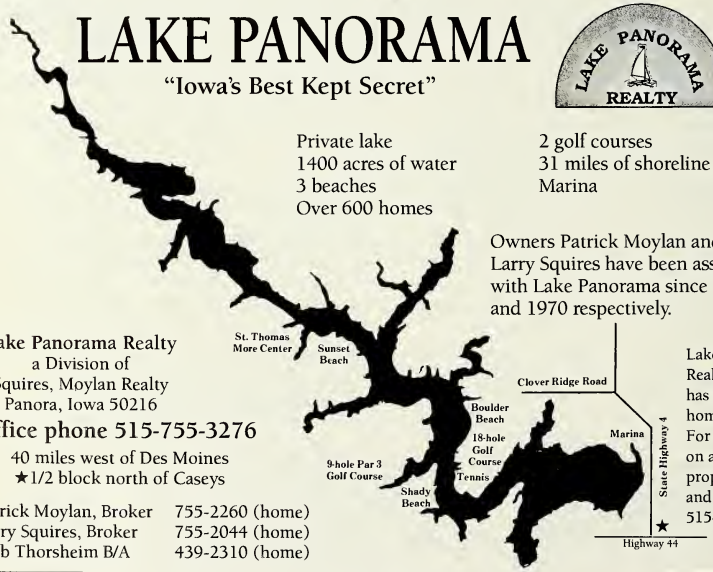
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This article was written by Karin George, office manager for Surgery P.C. in Des Moines. She is vice president of the Iowa Medical Group Management Association.

Quanta of Ambiguity

Richard M. Caplan, M.D.

TO TOLERATE AMBIGUITY or uncertainty seems crucial to one's comfort as a medical practitioner. If discomfort rises excessively when crisp answers aren't forthcoming, or things don't add up right, it may lead to diagnostic or therapeutic maneuvers that are risky, costly or fruitless—all detrimental to the patient's welfare.

Training in mathematics and "hard sciences," where the naive ones think precisely correct answers are always available, is crucial to learning basic medical information. But when pushed excessively, it can cause a medical newcomer (and some old fogies, too) to have a fit of the wim-wams when confronting a diagnostic or therapeutic riddle. The compulsion to know and understand all—otherwise, how can one make a diagnosis?—must be mastered and is, by most competent practitioners. It takes time, though. Even decades.

The qualms produced by clinical uncertainty can generate enormous, wasteful charges, no longer tolerable in this era of cost consciousness. When does one learn to trust one's clinical judgement, and what helps develop that trust? I submit, as I've come to watch students of medicine from ages 20 to 80, that a richer background in studying history, literature and social sciences, for example, could help. But the study of those disciplines must lead the student to understand, deep down, that history, for example, is not just a list of milestone events. The student—consider it CME—must learn to understand and accept the grand chaos, the magnificent disorderliness, of human beings. Then might come the wisdom or sensitivity to what is often called "the human condition."

When physicists thought energy was transmitted as waves only, an "ether" had to be postulated, for otherwise waves could not be propagated. When photons and quanta of energy were introduced into physics by Max Planck and his contemporaries, the ether became as unnecessary as phlogiston. With the introduction of scientific principles and rigor into medicine, starting in the Renaissance and especially in the past century, the role of the physician's memory and intuition seemed headed for oblivion. Advances in biological chemistry, imaging, genetics and immunology suggest to some (zealots) that the bedside computer, with its access to data bases and its meta-analyses of conflicting results from large double-blind trials, will lead to a medical utopia where decisions can be almost error-free. Such wild-eyed optimists may be entitled to some of that enthusiasm in the domain of diagnosis, but therapy will always confront the capriciousness of human beings, those practitioners of Murphy's Law, whose minds and/or bodies will forever punch other buttons during the process of medical computation.

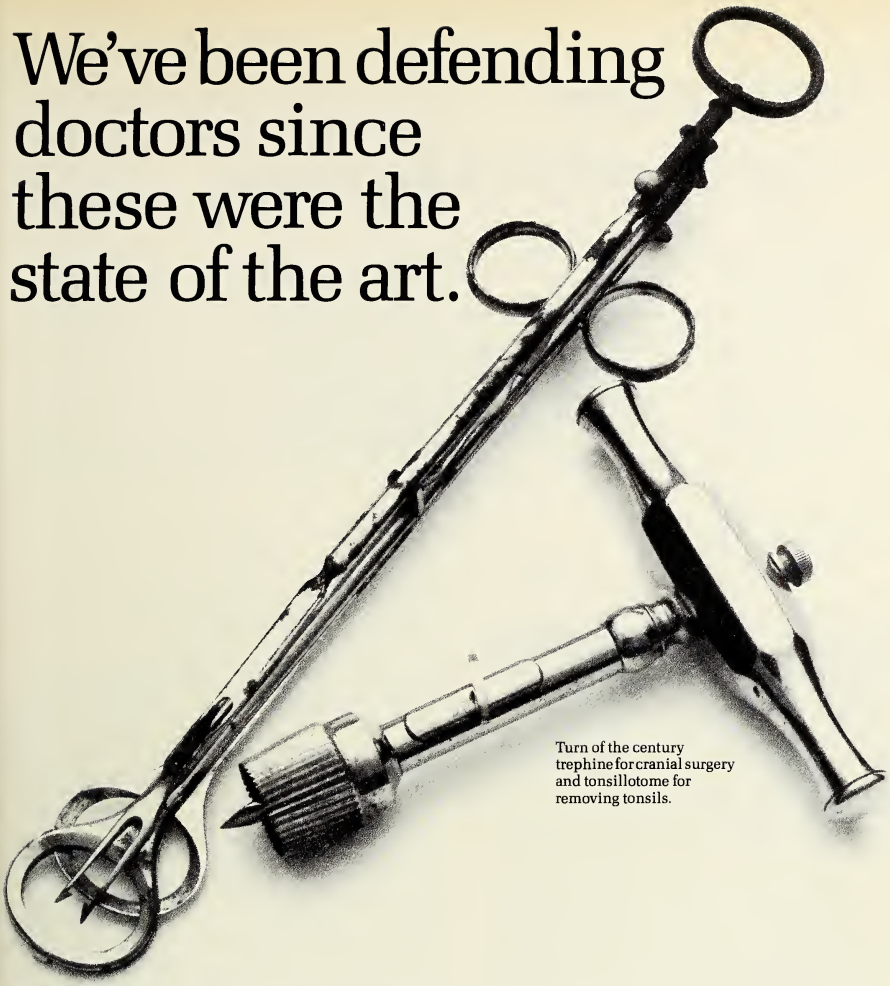
A dour perspective is this one, made during a discussion of a rational approach to clinical trials of psychotropic drugs: "In biology, and in medicine in particular, if a problem looks simple, it is because of ignorance. All problems are complicated and they look simple only because the complications have not been discovered." What is termed "evidence-based medicine" is now being described and taught, heralding a futuristic vision of ever-better approximations to truth, which will require ever less flying-by-the-seat-of-the-clinical-pants memory, deductive reasoning and intuition.

Lest this wave of futurism be ridiculed at its onset, here is a quantum of moderating wisdom from some leading futurists (*JAMA*, November 24, 1992): "It follows that clinicians must be ready to accept and live with uncertainty and to acknowledge that management decisions are often made in the face of relative ignorance of their true impact."

Amen!

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

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OPENING, FAMILY PRACTICE—Location: one hour from Twin Cities. Call: one in 7. Group size: 6 physicians. Salary: $100,000. Signing bonus: $25,000. Loan forgiveness: $50,000/5 years. Lake living: choice of 2 adjacent to our community. Contact: call collect 612/796-6220 (8 a.m. to 10 p.m.). Also available openings in general surgery, orthopedic surgery and OB/GYN within one hour of Twin Cities. Excellent compensation packages available with bonuses and loan forgiveness program.

ACUTE CARE, INC./EMERGENCY MEDICINE/LOCUM TENENS—Seeking quality physicians interested in emergency medicine or primary care locum tenens positions. Full-time and regular part-time. Numerous Iowa locales. Democratic group, highly competitive compensation, paid St. Paul malpractice with unlimited tail, excellent benefit package/bonuses to full-time physicians. Contact Acute Care, Inc., P.O. Box 515, Ankeny, Iowa 50021. Phone 1-800/729-7813 or 515/964-2772.

HERE'S A FAMILY PRACTICE OPPORTUNITY FOR YOU!—Join a progressive group of 7 family/general practice physicians, one general internist, 2 general surgeons and 2 physician assistants in a unique rural practice. Practice includes 3 branch medical clinics in family-oriented rural communities in 20 mile radius from hospital. Medical clinic attached to hospital in excellent new facilities. Guaranteed salary with incentive, full range of benefits, liberal time off. For more information, contact McCrary-Rost Clinic, P.C., Ed Maahs, C.E.O., or Dave Linder, Vice President, Iowa wats 800/262-6230 or 712/464-3194.

FAMILY PRACTICE PHYSICIAN, NORTH CENTRAL IOWA—The Rohlf Memorial Clinic Corporation in Waverly is seeking 2 Board Certified family physicians between July of 1993 and July of 1994 for a broad range of family practice. Excellent benefits and compensation. A complete description is available upon request. Work with an excellent community hospital now undergoing a $3 million renovation. Hospital staff support by specialties from Waterloo and Cedar Falls available. If interested please contact Michael T. Berstler, M.D., 220 10th Street S.W., Waverly, Iowa 50677 or phone 319/352-4340.

MANKATO CLINIC, LTD.—A progressive group practice is seeking additional BE/BC physicians in the following specialties: family practice, invasive cardiology, oncology/hematology, orthopedic surgery and general internal medicine practice. The Mankato Clinic is a 55-doctor multispecialty group practice in south central Minnesota with a trade area population of +250,000. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information, call Roger Greenwald, Executive Vice President or Dr. B. C. McGregor, President, at 507/625-1811 or write 1230 East Main Street, P.O. Box 8674, Mankato, Minnesota 56002-8674.

FAMILY PRACTICE, MINNESOTA—BC/BE family practitioner to expand current 23-member department. Enjoy a lifestyle of call every 21-23 days and an average 4-day work week. Just 20 minutes north of downtown Minneapolis, the area offers suburban living with easy access to an unlimited array of family, cultural, educational and recreational opportunities. Members of our physician-owned and directed group earn a highly competitive income and excellent benefits including paid vacation and CME, pension plan, all insurances paid and partnership potential after one year. Please respond with CV to John Bordwell, M.D., Medical Director, Comprehensive Medical Care, 9055 Springbrook Drive, Coon Rapids, Minnesota 55433; 612/780-9155.

INTERNAL MEDICINE, MINNESOTA—Progressive primary care based multispecialty group seeking BE/BC internist to expand existing 3-person department. We are looking for someone interested in inpatient as well as out-patient medicine. Subspecialty interest would be an advantage. Located just 20 minutes north of downtown Minneapolis, the area offers suburban living with easy access to an unlimited array of family, cultural, educational and recreational opportunities. Members of our physician-owned and directed group earn a highly competitive income and excellent benefits including: paid vacation and CME, all insurance paid and partnership potential after one year. Please respond with CV to John Bordwell, M.D., Medical Director, Comprehensive Medical Care, 9055 Springbrook Drive, Coon Rapids, Minnesota 55433; 612/780-9155.

PHYSICIAN FACULTY, FAMILY PRACTICE RESIDENCY PROGRAM—Clarkson Family Medicine started its Family Practice Residency on July 1, 1991. With a rapidly growing patient base and with anticipation of repeating our success in filling all resident positions in the MATCH, we are seeking additional educators to join us in preparation for our third residency class of 1993. ABFP certification, practice or teaching experience and OB skills required. Join us and be a part of the development and growth of Clarkson Hospital's only residency program. Excellent salary and benefits. Clarkson takes pride in being a smoke-free environment and does not hire applicants who use tobacco products. EOE. Send CV and letter of inquiry to Richard A. Raymond, M.D., Director, Clarkson Family Medicine, 4200 Douglas Street, Omaha, Nebraska 68131.

CHARLES CITY, IOWA—Seeking full-time and part-time physicians for low volume ED at this progressive 55-bed hospital. Weeknight cover-

age (6:30 p.m.-6:30 a.m.), with extended coverage in future. Democratic group, excellent compensation, paid malpractice insurance with unlimited tail coverage and full benefit package to full-time staff. License reimbursement for out-of-state physicians. Many other locations currently available. Contact Acute Care, Inc., P.O. Box 515, Ankeny, Iowa 50021; 1-800/729-7813.

LAB EQUIPMENT FOR SALE—Dupont Analyst, $5,500. Contact John Hensel, Physician & Clinic Services, 515/263-5450.

DERMATOLOGY, NEUROSURGERY, OCCUPATIONAL MEDICINE, ONCOLOGY, ORTHOPEDICS, ORTHOPEDICS-HAND, UROLOGY —Strelcheck & Associates, Inc., an extension of our clients recruiting departments, has positions available in Wisconsin and Michigan. We would be happy to provide you with further information. Please call 1-800/243-4353 or send your CV to Strelcheck & Associates, Inc., 10624 N. Port Washington Road, Mequon, Wisconsin 53092.

OB/GYN, INTERNAL MEDICINE, FAMILY PRACTICE—Strelcheck & Associates, Inc. currently represents family practice positions in Nebraska, Kansas, Texas, Illinois and Wisconsin—some near the Minnesota border; internal medicine positions in Wisconsin and Ohio; OB/GYN positions in southeastern Wisconsin. We would be happy to provide you with further information. Please call toll-free, 1/800-243-4353 or send your CV to Strelcheck & Associates, Inc., 10624 N. Port Washington Road, Mequon, Wisconsin 53092.

OB/GYN—Female seeks BE/BC partner for her growing Midwest practice. Competitive salary guarantee of $150,000+ with full benefits. Young medical staff at hospital with MRI, CT, ultrasound, laser, laparoscopy, YAG, centralized monitoring unit. Medical draw area of 45,000. Family lifestyle community with stable economy, low crime, excellent public schools, local nursing school. Numerous recreational activities, lake, golf. Send CV to Barb Inselman, 10983 Granada #202, Overland Park, Kansas 66211 or call 1-800/533-0525.

GENERAL SURGEON—Needed for solo opportunity with shared call. 100% surgery practice in patient draw area of 45,000. New hospital with CT, MRI, endoscopy, laparoscopy. Midwest family community and sailing, fishing, watersports, camping. Call Barb Inselman at 1-800/533-0525 or send CV to 10983 Granada #202, Overland Park, Kansas 66211.

LINK ETHICAL THEORY WITH CLINICAL PRACTICE—Applied ethicist sensitive to clinical dilemmas can meet the program needs of your group or medical society with topics ranging from an evaluation of the Canadian Health Care System, Rx in the Rural Trenches, Ethics of Assisted Suicide, Healing By the Fundamentals, etc. Published in *NEJM* and other leading U.S. and Canadian medical journals. CV, brochure and publications on request. Walter W. Benjamin, Ph.D., Hamline University, St. Paul, Minnesota 55104; 612/641-2300.

SIOUX CITY—An excellent position is available for a BC/BE family practice physician in a new community health center. A full range of family practice medicine is needed in a community that is very supportive of the center. Sioux City is a great place to raise a family and has excellent public and parochial school systems, a community college, 2 liberal arts colleges, a graduate center, 2 excellent medical centers, a Residency Training Program (family practice), etc. The center offers a competitive compensation and benefit package, paid malpractice, etc. For more information write Jeff Hackett, Executive Director, Siouxland Community Health Center, 1709 Pierce Street, Sioux City, Iowa 51105 or call 712-252-2477.

PEDIATRICS, ORTHOPEDIC SURGERY, FAMILY PRACTICE, INTERNAL MEDICINE—UPPER MIDWEST—B/E or B/C physicians for partnership in lakes and trees community. Shared call, fully equipped and staffed office, very competitive guaranteed salary and comprehensive benefit package. Also numerous LOCUM TENENS positions available. For information on opportunities in the upper Midwest, send CV to Mary Jo Cordes, President, MDSearch, P.O. Box 21507, St. Paul, Minnesota 55121 or call 1-800/484-9645, ext. 7291; collect 612/454-7291 or fax 612/454-7277.

ASSISTANT DIRECTOR FAMILY PRACTICE RESIDENCY—Established, community-based, University-affiliated, unopposed 6-6-6 residency enjoys strong hospital and medical community support. We seek a residency-trained, board-certified physician. Prior practice experience, including obstetrics, preferred. Position includes teaching and patient care. Administrative responsibilites commensurate with experience. Competitive salary and benefits. Send CV to John Sutherland, M.D., Waterloo FP Residency Program, 441 E. San Marnan, Waterloo, Iowa 50702; 319/234-4419.

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The Raiter Clinic, Ltd. is an equal opportunity employer



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ACCESSIBLE DOWNTOWN MEDICAL OFFICE—Currently a doctor's office. Nice reception area, small play area for children, large business office, restroom, lab, 5 treatment rooms, large personal office and additional large room for meetings/lunchroom/miscellaneous. 100 Court Avenue Building, near new skywalk connection; visitor and monthly parking available; affordable rent; 2200 square feet. Call 515/282-2106.

TIRED OF THE RAT RACE?—Anxious about entering private practice with the attendant risks and demands of the 90s? Why not consider emergency medicine. If you are trained in family practice or emergency medicine and are looking for a career with fixed hours, guaranteed income free of financial risks and other practice hassles, please give me a call. Kenneth P. Schultheis, D.O., President, Emergency Physicians Services, P.C., c/o Mercy Hospital Medical Center, Des Moines, Iowa; 515/247-4445.

WISCONSIN—Growing southern Wisconsin, 47-physician, multispecialty group is seeking an endocrinologist, general surgeon, internist, neurologist, ob-gyn, ortho surgeon, physiatrist and rheumatologist. Guaranteed salary with incentive plus full benefit package. Excellent family environment in college community of 50,000+. Send CV to J.F. Ruethling, Administrator, Beloit Clinic, S.C., 1905 Huebbe Parkway, Beloit, Wisconsin 53511 or call 608/364-2200.

(Continued next page)

EMERGENCY PHYSICIAN—Full or part-time. BE/BC in primary care specialty or emergency medicine. Competitive salary and benefit package. Call 515/263-5263 or write: Larry J. Baker, D.O., FACEP, Medical Director, Emergency Department, Iowa Lutheran Hospital, University at Penn, Des Moines, Iowa 50316.

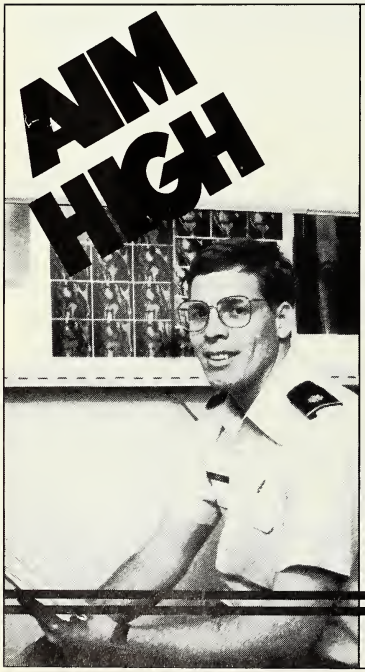
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COGLEY MEDICAL ASSOCIATES, P.C.—A progressive multispecialty group practice is seeking BE/BC physicians in the following specialties: family practice, internal medicine and general surgery. CMA is a 14-doctor group with complete laboratory, radiology and physical therapy services. First year salary guarantee, full range of benefits and attractive buy-in option after first year. For more information, contact Richard F. Lehigh, Administrator, Cogley Medical Associates, P.C., 715 Harmony, Council Bluffs, Iowa 51503; 712/328-1801.

EMERGENCY MEDICINE—Outstanding, professional opportunities in emergency medicine available in a variety of great Iowa locations. Quality lifestyles in family oriented communities. Comprehensive compensation packages for primary care trained or experienced emergency physicians. Administrative and staff positions with a progressive, physician owned contract staffing group. For immediate consideration call Sheila Jorgensen at 1-800/458-5003 or mail CV to Emergency Practice Associates, P.O. Box 1260, Waterloo, Iowa 50704.

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William Eversmann, Jr., M.D.

Patriotism and bigotry

These are the times that try men's souls. The summer soldier and the sunshine patriot will, in this crisis, shrink from the service of their country.
—Thomas Paine
December 23, 1776

SEVERAL WEEKS AGO in his State of the Union address, Mr. Clinton raised the issue of patriotism as we attend to the economic needs of this great country. Webster's dictionary defines patriotism as "the loving and loyal or zealous support of one's own country, especially in matters involving other countries." A listener to Mr. Clinton's speech had to be impressed. I would have been more impressed if he had dated his patriotism from 1965 to 1972 rather than to a few months in 1993.

As Samuel Johnson said in April of 1775, "patriotism is the last refuge of a scoundrel."

But what of bigotry? Webster defines bigotry as "obstinate or blind attachment to a particular creed or unreasonable zeal in favor of a party, sect or opinion." Once again, Mr. Clinton is engaged in the only acceptable form of bigotry in the U.S.—bigotry against the well-to-do. He assumes the well-to-do have not paid their share, though they have paid their share and more-so either in taxes, donations, personal service or leadership.

As physicians, we now come under the scrutiny of both Mr. Clinton *and* the president in the form of health care reform. We can anticipate a variety of "announcements" before the Clinton Plan is released. Once the plan is fully revealed, we must be responsible for informing the public of the implications of the Clintons' reform policy and its effect on the health care delivery system.

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The Editor Comments



Marion E. Alberts, M.D.

Trend-setting isn't always a good thing

FRAUD IN THE PRACTICE of medicine apparently has flourished in a number of large cities. *Prime Time Live*, aired on ABC television February 11, purported widespread fraud in the Los Angeles area.

By means of a "dummy" medical office equipped with cameras and sound equipment, the operation of one type of fraud was exposed. The scheme involved kickbacks to physicians for referring patients, whether ill or not, to various specialists. Brokerage-type groups would provide the "patients," provide a fee and the specialists could extract large fees for the referrals.

Workers compensation cases were the favored target. False claims would be made regarding injuries, the referrals made and the money for the false claims added to the unscrupulous physicians' already exhorbitant income. It was suggested some were the recipients of multimillion dollar annual incomes. The kickback fees were submitted to a phony collection company to protect the "good name" of the referring physician.

Another form of kickback was to allow the referring physician to submit a bill for services not personally rendered. For example, for every 10 cases referred for MRI studies the referring physician, by previous arrangement, would bill for four of them.

Imagine a middleman coming to your office offering to provide "patients" to you, giving you several hundred dollars for each that you referred. The unscrupulous specialist could then increase his or her income by millions.

Some companies in California have had to declare bankruptcy or alter their employee insurance programs because of the greatly increased insurance premiums resulting from such fraud.

California is not the only area involved in such fraudulent schemes to extract insurance benefits. Increasing surveillance will ferret out the persons involved. The report by ABC will expose such schemes. It is hoped the legal systems will handle these incidences in a judicious manner and provide stiff punishments to the offenders.

Iowans are not known to be trend setters. Let us hope that no such schemes appear to tarnish the medical profession here. Physicians must hold themselves above fraud and unjust schemes. Our task and responsibility is to provide excellent medical care in an honest manner.

Primary care: concern and debate

FOR MANY YEARS, the University of Iowa College of Medicine has focused on helping Iowa meet its need for more generalist physicians, a matter of concern and debate in every state in our country.

In the College's increased efforts to help Iowans deal with the challenges of health care for the elderly, AIDS, environmental issues and many others, we in the College continue to struggle with the challenge of primary care availability and its effect on rural health care in our state.

The challenges

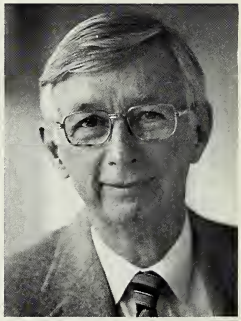
The challenges affecting the primary care physician supply and distribution include: practice environment, practice content, economic factors, cultural factors and medical education.

The College has direct control over only one of these factors—medical education. Cultural factors and practice content are largely determined by the community setting and population demographics. However, through two important committees, we will be able to focus on specific issues dealing with the supply and distribution of primary care physicians and can work to influence the economic factors and practice environment aspects.

The Family Practice Advisory Committee will meet with us several times each year to consider family practice issues and has several goals:

- Promote family practice to medical students
- Determine which factors encourage students to select family practice and which discourage them
- Understand why family practice graduates choose to practice in Iowa and why they do not

James Clifton, M.D.



- Determine the factors that cause physicians to leave family practice and go into another field and/or leave the state and practice elsewhere.

This committee will include family practitioners in private practice (to be recommended by the Iowa Academy of Family Practice), members of the UI Department of Family Practice and representatives from the Iowa Medical Society and the Iowa Department of Public Health.

Another committee will include College of Medicine faculty who are expert in defining underlying economic, social, demographic and epidemiological factors in areas of Iowa that are underserved by health care workers. The College of Medicine's Office of Community-Based Programs will continue to promote recruitment of family practitioners to Iowa.

We are also establishing a team of family practitioners, including our own faculty, which will visit Iowa high schools and share with students the rewards of rural practice and primary care.

More changes on the horizon

A recent year-long planning process has resulted in an initiative from the College that calls for, among other things:

- A full-scale review of the medical school curriculum, with increased emphasis on primary care instruction and additional educational experiences in community-based settings
- Enhanced efforts that support recruitment and retention of faculty in the primary care disciplines
- Expanding current activities to assist primary care residents and physicians in establishing Iowa practices.

Assuring access to primary health care is a complex issue. It cannot be solved by one group or any single organization.

Even as we seek answers to the rural physician supply problem, we must continue to emphasize the key role the College plays in providing physicians in all fields for the state. More than 50% of all physicians practicing in Iowa either graduated from the College or received post-graduate training in residency programs associated with the College. That achievement is particularly significant considering that less than 10% of the College's budget comes from state appropriations, less than the amount needed to teach our students. The remainder of the collegiate budget is generated by the faculty. Changes in patient referral patterns and reimbursement systems have the potential to impair the ability of the College to maintain this record of unparalleled service to the state.

More to enter primary care

There is some good news ahead. Early indications are that about 30% of our 1993 graduating class plan to enter family practice and another 22% plan to enter internal medicine and pediatrics. During the 1980s, medical students retreated from primary care, but the pendulum appears to be swinging back.

We in the college will strive to do all we can to foster the ideals of primary medicine, but we cannot do it alone. Fortunately, we continue to receive the valuable assistance of the Iowa Medical Society and the Iowa Academy of Family Practice. With all sectors—College, communities, state government, IAFP and IMS—working together, we can solve these problems.

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Attitudes toward primary care are changing

There are encouraging signs that student interest in primary care is growing, say physicians with the University of Iowa College of Medicine.

IOWA'S MEDICAL GRADUATES CHOOSE careers in primary care fields at twice the national average rate, but demand for physicians in Iowa is still surpassing supply.

As in other states across the country, many Iowa communities are searching for primary care physicians.

Encouraging signs

There are encouraging signs that interest in primary care medicine is growing.

The graduating class of 1993 at the University of Iowa College of Medicine may signal a changing attitude among medical students. More than half of the class has selected a residency in either family practice, general internal medicine or general pediatrics. This figure is the highest over the past decade.

"It is gratifying to see a greater interest in primary care by our students. Not only will these graduates help meet the state's needs, but they will enter an area of practice that is challenging and rewarding," says Dr. Peter Densen, professor of internal medicine and acting associate dean for curriculum. Dr. Densen also chairs the Medical Education Committee, which is currently reviewing the curriculum.

"The college's renewed curriculum will place greater emphasis on ambulatory care in general," Dr. Densen says. "It's important to remember that pediatricians, obstetricians and general internists all practice primary care. That is why the college is emphasizing broad-based interdisciplinary approaches from these and other specialties in the development of new clinical programs. We are also making great strides by increasing the numbers of interdisciplinary teaching initiatives that involve ambulatory and primary care in the clinical setting."

Many students selecting primary care careers consider the nature of the field the biggest attraction, not a deterrent.

"In my third-year rotations and during the family practice preceptorship, I saw the importance of the physician's personal relationship with the patient. The continuity of care in primary care fields was most attractive to me," says Sonia Sather, a fourth-year medical student from Anamosa, who will soon enter a family practice residency.

Generalism is attractive

The concept of following a patient for the long-term is what many students cite as a basic reason for choosing primary care. "I really enjoy focusing on the person as a whole and on developing a relationship with the patient and family," says Gina Batterson, a fourth-year student from Ottumwa, who will be entering an internal medicine residency.

(Continued next page)

The generalism of primary care is also attractive to many students. "My rotation at a clinic made the greatest impression. I really enjoyed talking to the patients. I also enjoy many facets of medicine and family practice is the best opportunity for me to use them all," says Dean Moews, fourth-year student from Ackley. Moews did not set out to be a primary care physician. "Until the third year of medical school, I was going to be a surgeon. I even participated in some research my first year. But then I took a hard look at what I really enjoy most and what I am interested in, and it turned out to be primary care," Moews says.

Appreciation and respect for primary care physicians among students has also grown. The medical school experience has much to do with this: "Everyone has a little bit of a stereotype in mind when they start, but you lose that as you go along," Sather says.

"Before, many people viewed a primary care doctor as someone with a stethoscope and a bottle of sugar pills, but it's not like that. These physicians have to have an extraordinary knowledge base and rapport with patients," says Ian Law, a fourth-year student going into pediatrics.

Iowa's primary care physicians themselves deserve much credit for the field's changing image. "Those who serve as preceptors have done a good job in selling primary care and have influenced student choices. Patients in these communities have also given willingly by acting as 'teachers' for medical students," says Dr. Charles Driscoll, UI professor and head of family practice.

Students interested in primary care do a lot to spread the word about the field themselves. Sather is co-president of the UI Family Practice Club, which organizes a variety of activities that provide a backdrop for formal and informal interaction between medical students and practicing physicians. These include a speaker series, a chili supper with family practice residents and a "shadow" program that allows students to spend a day during winter break with a hometown doctor.

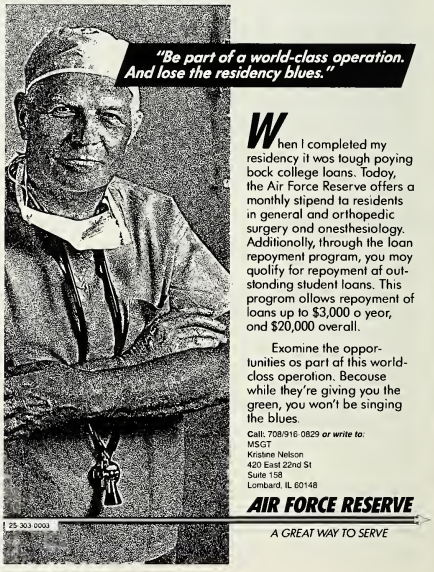
Beginning a trend

The new value being placed on primary care on a national level is also playing a role. "There is lots of hope that new legislation on reimbursement policy, and loan programs will make a difference," Dr. Driscoll says. The high demand for primary care physicians nationally is making students optimistic that they'll be positively rewarded for their choice, he adds. The field itself is also becoming more accommodating, with the advent of more options for financial arrangements and working hours.

And students are getting the message. "Our nation's health care system may be in flux in the future as the nation tries to address inequities. But the need for primary care physicians will keep increasing, no matter what system we adopt," Law says.

Dr. Driscoll predicts that the 1993 class is a beginning of a trend of more primary care physicians. "Students are realistically goal-directed and are beginning to change their value system. They want to be part of the solution to the problem."

"I want to be the problem solver. I'll treat it if I can, or else refer the patient on to a specialist if necessary. Later they'll come back to me," says Moews. "As a primary care physician, the patient's health is truly in your hands."



UI Hospitals touches every part of Iowa

Outreach clinics of UI Hospitals and Clinics provide consultation, education and support services to physicians and patients across Iowa.

As the only internal medicine specialist in Jackson County, Paul Barber, M.D. is often called upon for subspecialty expertise.

"Especially cardiology," the 41-year-old Maquoketa physician says. "That's why I was really interested in a medical visitors program at the University of Iowa."

Designed for primary care practitioners, the medical visitor program in cardiology enables Iowa physicians to spend a day with UI cardiologists to discuss topics of special interest. Dr. Barber requested sessions on signal average ECG and holter monitoring techniques.

"It was the best learning symposium I've ever run across," Dr. Barber says. "It's a great opportunity to go one-on-one and ask questions of some of the foremost specialists in the field."

Dr. Barber is one of several thousand Iowa practitioners who benefit from scores of outreach services provided by the University of Iowa Hospitals and Clinics and the UI College of Medicine. A survey conducted in 1991 by Douglas Wakefield, Ph.D., associate professor in hospital and health administration at the UI, found these outreach activities include more than 350 formal and informal programs and clinics.

Among the most visible programs are the outreach clinics providing consultation, education and support services to patients and physicians in various Iowa communities. John Fieselmann, M.D., director of outreach programs in the UI Department of Internal Medicine, says these monthly clinics "complement existing medical care programs in these communities and improve convenience for patients who live some distance from Iowa City."

Patients can receive chest x-rays, pulmonary function tests, biopsies and EKG monitoring locally in an outreach clinic. Anyone requiring specialized tests or entrance into national protocols can be further evaluated at UIHC and then receive follow-up care from their community physician.

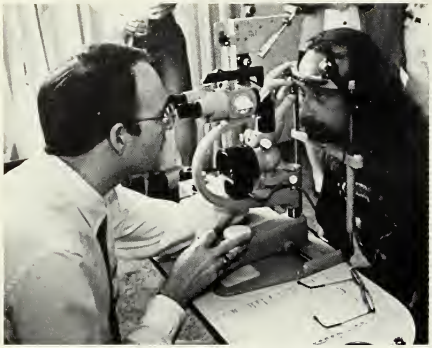
Current outreach clinic sites include Burlington (endocrinology and rheumatology); Keosauqua (cardiology, pulmonary, and dermatology); Mount Pleasant (hematology/oncology, pulmonary, and urology); Muscatine (hematology/oncology, cardiology, and pulmonary); and Ottumwa (cardiology and rheumatology).

Also, children with known or suspected chronic health problems receive patient evaluation and treatment through child health specialty clinics. Various pediatric subspecialties sponsor clinics in sites ranging from Davenport to Sioux City and Mason City to Creston.

The Iowa Childhood Cancer Diagnostic and Treatment Network Program promotes childhood cancer care in the patient's home community through a sophisticated computer-assisted patient management program.

"Computerized treatment forms contain detailed lists of drugs and procedures and information about related potential toxicities,

(Continued next page)



Some University of Iowa researchers take to the road to gather data. For a study of inherited eye diseases, Dr. Edwin Stone and his colleagues set up shop in an Ottumwa motel to examine 40 related family members.

dosage and dose modifications that allow oncologists and non-oncologists alike to follow protocols accurately and efficiently," says Thomas Kisker, M.D.

Virtually every department sponsors education and training activities. These include programs on hospital epidemiology, AIDS, nursing, eye donation, spine health care, perinatal care, genetic consultation, newborn screening, pathology laboratory services, mammography, cardiac surgery, aging and dozens of formally structured education programs sponsored by the Division of Continuing Medical Education in the College of Medicine.

UI specialists also provide consultation and assistance services to all corners of the state. One popular service helps nursing homes and hospitals establish special care units for Alzheimer's patients, provides information on managing difficult behaviors and assists Alzheimer's support groups with speakers.

Yet another program enables eight community hospitals in Iowa to provide improved occupational medical care to the state's workforce. The occupational medicine associates network is an outreach service organized by Worksafe Iowa and conducted in collaboration with UIHC.

"Each hospital can consult Worksafe Iowa's health professionals, including industrial hygienists, occupational medicine physicians, toxicologists, epidemiologists, health educators and information specialists," says James Merchant, M.D., director of Worksafe Iowa and the Institute of Agricultural Medicine and Occupational Health.

One new outreach initiative may herald an exiciting era in communications among hospitals, according to some experts. The state's planned fiber optics network presents the potential to link Iowa urban hospitals, rural hospitals and physicians and educators providing medical communication and educational opportunities, says Perry Meyer, director of the Iowa Hospital Association information center.

To show the system's potential, the UIHC is developing a demonstration fiber optics project with Van Buren County Hospital in Keosauqua.

Wakefield says the scope of UI's outreach programs extends beyond formal programs. "When you also consider that education, technical assistance and research constitute other forms of outreach, it is readily apparent how the university touches all parts of the state," he says.

Beef Industry provides free nutrition materials for physicians and patients

THE IOWA BEEF INDUSTRY COUNCIL is providing free informational booklets to physicians for their patients and professional office staff. The booklets, published by the National Livestock and Meat Board, are free of charge and may be ordered in quantities.

A one-half hour video entitled "Practical Strategies for Improving Dietary Compliance in Hypercholesterolemia" is also available. "Practical Strategies" has been reviewed by the AMA's scientific and continuing medical education divisions and has been approved for one-half hour CME credit.

To obtain any of these free written or video materials or for more information contact the Iowa Beef Industry Council, P.O. Box 451, Ames, Iowa 50010; phone 515/232-0428; fax 515/223-5531.

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The American Heart Association and the National Cholesterol Education Program have recognized the place for lean beef in a varied, balanced diet. Both of their dietary guidelines recommend up to 6 oz daily of lean beef and meats, poultry, or seafood.[3,4]

Here are guidelines that can help your patients enjoy beef that's compatible with a heart-healthy diet:

- Purchase lean cuts
- Keep portions moderate (3 oz cooked)
- Remove visible fat before cooking
- Prepare without additional fat

References:

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BALTIMORE

Understanding the problems of the elderly

As the number of elderly Iowans increases, UI researchers are stepping up efforts to understand their unique health problems.

THE GRAYING OF AMERICA is rapidly increasing and Iowa is surpassing all other states. While the population of the state as a whole decreased during the 1980s, the number of people over 65 increased by 38,000. Iowa already leads the nation as the state with the highest percentage of adults over 85.

Health care providers increasingly address the unique needs of elderly patients, particularly the rural elderly. Rural elderly are not the same as those in urban areas. They have lower average incomes, they are more likely to live in substandard housing and have less access to public transportation and a comprehensive array of health services.

A number of UI research efforts are examining the special care needs of geriatric patients. The 65+ Rural Health Study is one of four national studies sponsored by the National Institute on Aging. It aims to characterize risk factors for disease, dysfunction, institutionalization and death. Follow-up interviews have provided a compilation of vital information on a range of clinical topics and provide an invaluable profile of Iowa's rural elderly and their health status.

Assessing the health status of elderly patients and making decisions regarding their capabilities and independence as well as their physical health is often difficult. Researchers at the UI Colleges of Medicine and Nursing have jointly produced the Iowa Self Assessment Inventory, a comprehensive and efficient instrument that can help assess an elderly patient's economic resources, emotional balance, physical health, trust of others, mobility, cognitive status and social support. Currently it is in use by many of Iowa's health care providers and those in contiguous states.

Mobility means independence for most people, yet determining whether one is fit to drive an automobile is a difficult call. There is increasing concern about the implications of impaired persons—including older individuals—and driving, but there is little information about the relationship between specific characteristics and a patient's competency in driving. College of Medicine researchers are working with the Iowa Driving Simulator project to develop a standardized test battery and an on-road test. These are potential screening tools for assessing the impact of treatments on impaired drivers. In the study, researchers will examine 500 men and women over 50 who have experienced a stroke.

Much of the research that may benefit older individuals is being conducted on a very basic level. Studies in the area of degenerative neurological diseases are looking into

(Continued next page)

Contributors to this article were: Donald Heistad, M.D., professor of internal medicine and director of the UI Center on Aging; John Rachow, M.D., Ph.D., assistant professor of internal medicine and director of the Iowa Geriatric Education Center—both of the UI College of Medicine; and Kathleen Buckwalter, B.S.N., Ph.D., professor in the UI College of Nursing and co-director of the UI Center on Aging.

the mechanisms underlying memory, language and behavioral guidance, all of which are affected by aging.

In addition to clinical studies on strokes, experimental models of aging, hypertension and stroke are also being investigated. Numerous research projects in internal medicine are being conducted on the basic mechanisms behind these conditions and how they develop, such as the effects of aging on cardiovascular reflexes, cerebral circulation and atherosclerosis.

Understanding the basic mechanisms of aging and related health problems is also the focus of much study. Basic insight into the inflammatory process, decubitus ulcers, neuroendocrine disorders such as diabetes, degenerative disorders and oral health will help physicians in treating elderly patients.

New treatments alone cannot solve the health problems of the elderly. We also need more health care professionals trained in geriatrics to fill the enormous national need. The UI has established a number of programs to help train the next generation of researchers and care providers who have a knowledge base in geriatrics.

- **The Aging Studies Program** provides undergraduate and graduate students with a multidisciplinary approach to gerontology. This program provides students of various disciplines a broad background in aging.
- **The Center on Aging** integrates and enhances interdisciplinary research, education and service efforts dedicated to understanding the aging process and addressing the needs of the elderly. A research training grant from the National Institute on Aging supports five pre- and five postdoctoral trainees.
- **The Epidemiology of Aging Training Program** supports five predoctoral and five postdoctoral trainees.
- **The Hospital and Health Administration Aging and Long-term Care Specialization** program positions graduates to fill health care executive positions related to long-term care and home health care.
- **The Iowa Geriatric Education Center** provides training and education in geriatrics and gerontology to selected health care professionals from around the state. The center conducts educational courses and conferences and maintains a resource center that includes a large library of videotapes.

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Training for Iowa physicians

It is clear AIDS is a chronic disease that will have an impact on the public health of Iowans for years to come.

Louis Crist, M.A.
Iowa City, Iowa

DURING THE PAST FIVE YEARS, "MATEC" has become an increasingly familiar acronym to health professionals who wish to provide the best care for their patients who have the human immunodeficiency virus (HIV). The MATEC (Midwest AIDS Training and Education Center) is a consortium of academic, professional and public health organizations in Iowa, Illinois, Indiana, Minnesota, Missouri and Wisconsin. Its primary mission is to help health care professionals deliver effective care to the growing number of people with HIV infection and AIDS.

The UI College of Medicine administers the MATEC/Iowa Site and overall direction is provided by Charles Helms, M.D., Ph.D., professor of internal medicine. An AIDS Education Advisory Committee guides the staff on program and resource development, as well as on other matters related to the Iowa Site's education and training efforts.

From April, 1988 through December, 1992, educational activities, either sponsored or cosponsored by the Iowa Site, were conducted in 19 Iowa communities and attracted over 6,200 participants. See figure next page.

AIDS in Iowa

In 1992, 108 new cases of AIDS were reported in Iowa, eclipsing the previous annual high of 85 cases reported in 1991. Since the first case of AIDS was reported in Iowa on February 3, 1983, 425 cases have been reported. Although the number of cases reported in the state has remained relatively small compared to high-incidence regions of the United States, the impact of the disease on Iowa's health care community and the public is substantial.

It is clear that AIDS is a chronic disease and that it will continue to have an impact on the public health of Iowans for years to come. Primary care physicians and other health professionals across Iowa are being called upon in ever-increasing numbers to provide care and counseling for HIV-infected individuals and their families.

Clinical training program

The MATEC/Iowa Site offers a variety of multidisciplinary continuing education programs, outreach activities and training opportunities. The major focus is a patient-oriented, clinical training program for physicians, dentists, nurses, nurse practitioners, physician assistants and dental hygienists throughout the state who are involved in the primary care of HIV-infected patients.

This clinical training program offers information about HIV/AIDS that health professionals need for standard HIV identification and prevention activities, provides information primary care practitioners need to care for HIV-infected persons who are asymptomatic or beginning to experience symptoms and helps practitioners caring for persons at more advanced stages.

The MATEC/Iowa Site's clinical training program is offered free of charge. Following

(Continued on page 145)

Midwest AIDS Training and Education Center (MATEC)
IOWA SITE

COMMUNITIES REACHED BY MATEC/IOWA SITE
April 1988 - December 1992*



*Multiple educational programs have been conducted in many of these Iowa locations during the period.

PARTICIPANTS IN EDUCATIONAL ACTIVITIES SPONSORED BY THE IOWA SITE
April 1988 - December 1992

Nurses	2,323
Physicians	980
Dentists	46
Pharmacists	125
Physician Assistants	88
Social Workers	367
Health Educators	321
Health Care Administrators	152
Resident Physicians	204
Students in the Health Sciences	846
*Other	791
TOTAL	6,243

* Includes counselors, laboratory workers, dieticians/nutritionists, psychologists, therapists, attorneys, and other helping professionals.

an orientation to the Virology Clinic at UI Hospitals and Clinics, a visiting health care provider has the opportunity to directly observe patient examinations, consultations and medical procedures, as well as to join in clinical conferences. There is ample opportunity to ask questions, discuss treatment issues and concerns and observe the types of care and assistance AIDS patients and their families receive. Participants also explore a number of psychosocial elements associated with the disease. Visitors not only benefit from the increased knowledge and insight about AIDS patients and their needs, but the experience often enhances their ability to be "sensitized helpers" who can help increase the level of HIV/AIDS education and understanding in the community.

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UI researches environmental health risks

Iowans depend on UI researchers for valuable information about environmental health risks.

AGRICULTURE AND A FARM ECONOMY give Iowa its character. Yet there are a number of health risks inherent in farming: toxic properties of pesticides and herbicides contaminate water and soil, grain dust and other irritants affect respiratory health, farm injuries disable and kill farm family members and radon increases cancer risk.

The UI has been a leader in examining agricultural health risks to rural Iowans since the Insitute of Agricultural Medicine and Occupational Health was established in 1955. But, we still have much to learn about the extent of risk from toxic exposures, particularly those in a farm setting. Recently, a number of centers have been established that have focused UI efforts and are yielding results that have a statewide impact.

Toxic exposures and their adverse effects on health include more than just pesticides and agricultural chemicals. Studies conducted through the UI Center for Agricultural Disease and Injury Research, Education and Prevention have examined respiratory problems related to agricultural dusts. Recent results have shown that acute responses to these inhaled dusts can predict who will be at risk of developing chronic disease from the exposure. Farm family members are exposed to the same substances as farm workers themselves and a longitudinal study will track the health of farm and other rural families in Keokuk County for perhaps as long as 20 years.

In addition, UI researchers have just begun the largest cohort study ever attempted in order to examine the health effects of pesticides and other farming-related exposures in more than 75,000 Iowans.

Modern agricultural practices, namely the use of chemicals, have affected the quality of our water sources, a concern to all Iowans. Studies by faculty in the UI Environmental Health Sciences Research Center have found that a significant proportion of private water wells in the state are contaminated with bacteria and chemical residues, above accepted levels of safety. While the potential acute health effects of some of these exposures are documented, little is known about the health consequences of chronic exposures to low levels of these substances and the compounds that are left behind when pesticides break down.

(Continued next page)

Contributors to this article were: James Merchant, M.D., Dr.P.H., professor of preventive medicine and environmental health and director of the UI Institute of Agricultural Medicine and Occupational Health; James Hanson, M.D., professor of pediatrics and director of the UI Institute for Health, Behavior and Environmental Policy; Charles Lynch, M.D., Ph.D., assistant professor of preventive medicine and environmental health and co-principal investigator of the State Health Registry; and David Schwartz, M.D., associate professor of internal medicine and director of the Occupational Medicine Clinic at UI Hospitals and Clinics.

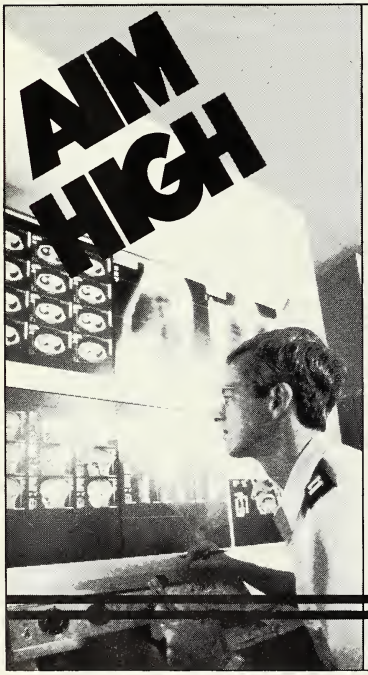
Even public water sources may be affected: A 1992 UI study recorded elevated levels of some birth defects in the population served by water supplies from Lake Rathbun. Researchers have not yet established a cause-and-effect relationship and further study is underway to examine possible causes—including the water supply—for the increase in birth defects.

Information like this from the Rathbun area is made possible through the university-based State Health Registry of Iowa, which records the rates of cancer and birth defects in Iowa. Annual reports provide estimates of new cancers and cancer deaths for the current year. This year, the report indicates breast cancer accounts for 30% of all new cancers among Iowa women.

Some of the registry's work is supported by funds from the UI Center for Health Effects of Environmental Contamination (CHEEC). This interdisciplinary group funds many pilot studies that lead to larger investigations. CHEEC has contributed to studies looking at Iowa's water supplies, examining high residential radon levels across the state and various aspects of specific chemical and environmental exposures.

Much of the information from these studies concerns risks to the public health. CHEEC and the UI Institute for Health, Behavioral and Environmental Policy are working with the Iowa Departments of Public Health and Natural Resources to develop a responsible state policy for communicating health risks related to environmental contamination issues, particularly reproductive risks.

The effort was prompted by data gathered in the UI studies of Lake Rathbun water supplies. It's not good policy to warn people without providing adequate information for consumers and health care providers to make decisions regarding risk, the researchers note.



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College of Medicine Highlights

HOARSENESS OR OTHER UNEXPLAINED CHANGES IN VOICE QUALITY can be early warning signs of throat cancer, especially for men over 50, report **Dr. Hughlett Morris, speech pathology** and **otolaryngology,** and **Dr. Duane Van Demark, otolaryngology.** In a follow-up study of 73 patients who had a total laryngectomy after being diagnosed with throat cancer, three of four reported that hoarseness or a change in voice quality were among their early symptoms. Other symptoms included problems with swallowing, sore throat and weight loss. While neither tobacco nor alcohol use by itself appeared to cause the cancer, 22% of study subjects were heavy users of both.

DR. JAMES HANSON, PEDIATRICS, has been appointed director of the UI Institute for Health, Behavior and Environmental Policy. The institute studies and develops public policies promoting health, prevention and control of disease. It participates in research, education and demonstration projects in health services, health behavior and environmental health policies. Hanson was previously director of the UI Division of Medical Genetics, a position he had held since 1977.

DR. DONALD HEISTAD, INTERNAL MEDICINE AND PHARMACOLOGY, is program director of a renewed $5 million NIH Program Project Grant on Cerebral Blood Vessels. The grant will support research on blood flow in the brain, high blood pressure and strokes. Other principal investigators on the grant include **Drs. Frank Faraci, internal medicine; Gary Baumbach, Michael Hart** and **Steven Moore, pathology; Stephen Lewis** and **Sean Murphy, pharmacology;** and **Robert Woolson, preventive medicine.**

THE CAUSES AND TREATMENT OF INFANT ANEMIA are the focus of a $4 million grant from the NIH. The study will involve four separate projects, led by **Dr. Ronald Strauss, pathology** and **pediatrics,** and **Drs. John Widness, Donald Mock** and **Edward Bell,** all of **pediatrics.**

THE RISE AND FALL OF BLOOD PRESSURE DURING DREAM SLEEP is linked to sympathetic heart activity, and possibly heart attacks, according to a new study by **Drs. Virend Somers, Francois Abboud, internal medicine** and colleagues. During REM sleep, sympathetic activity was far higher than when the person was wide awake, the researchers found. "In a person with underlying heart disease, the increased blood pressure during REM sleep may precipitate a heart attack," Somers noted. "Our research doesn't address therapy, and we would not want to deprive anyone of dream sleep, which is very important to a healthy person. However, the research supports the use of medicines that suppress the sympathetic nervous system," he added.

TWENTY-THREE IOWA HOSPITALS NOW BELONG TO A CONSORTIUM that monitors the quality of health care services provided to Iowans. The Iowa Hospital Quality Assurance and Enhancement Institute includes the UI Center for Health Services Research. Iowans benefit because hospitals which belong are now looking at opportunities to collaborate on ideas, techniques and information, say Project Directors **Drs. Douglas Wakefield, hospital and health administration,** and **Charles Helms, internal medicine.** Support comes from the Robert Wood Johnson Foundation.

(Continued next page)

ONE OF THREE WOMEN DIAGNOSED WITH CANCER IN IOWA in 1993 will have breast cancer, according to the State Health Registry of Iowa based at the UI College of Medicine. The Registry estimates 2,080 new cases will be diagnosed and 565 deaths will occur across the 99 counties of Iowa. "While the number of new cases of breast cancer may be declining nationally, this trend is not as noticeable in Iowa," says **Dr. Charles Lynch, preventive medicine and environmental health** and co-principal investigator of the Registry. The Registry also reported these facts: 14,000 new cancer cases will be diagnosed in Iowans this year; five of six cancers occur in Iowans age 55 or older; lung cancer caused one in four cancer deaths; and one-fourth of new cancer cases in men will be prostate cancer.

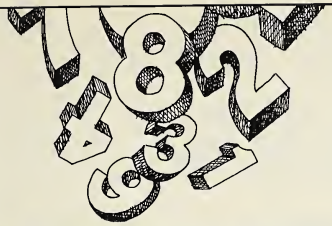
NEW MOTHERS MAY BREAST-FEED their newborns for a longer period of time if given a manual breast pump instead of infant formula when leaving the hospital. **Drs. Claiborne Dungy** and **Lois Dusdeiker, pediatrics,** say that breast-feeding is team relationship and that it takes a while for a mother and baby to be comfortable with each other. Because breast-feeding is portrayed as an easy and natural thing, mothers who find that it's not always that simple may become discouraged. UI researchers also say that short hospital stays of 24 to 48 hours, as well as lifestyle changes, such as returning to work, can also discourage mothers from breast-feeding. However, attitudinal differences among women appear to play a greater role in determining whether or not a woman will breast-feed.

HUMAN GENE THERAPY TRIALS for treating cystic fibrosis are being conducted by Howard Hughes Medical Institute researchers at the UI in collaboration with Genzyme Corporation of Cambridge, Massachusetts. **Dr. Michael Welsh, internal medicine,** and colleagues are testing the feasibility of using an adenovirus to deliver the cystic fibrosis transductance regulator (CFTR) gene by applying it to a small area in the nasal tract of CF patients. An adenovirus is created by taking a virus that causes the common cold and altering it to remove the portions that cause and produce illness. Then a normal version of the CF gene is inserted. Although the study will not be of therapeutic value to the first group of patients, scientists are optimistic that from this first step toward gene therapy, they will gather crucial data about the efficacy and safety of the method.

IOWA'S MONITORING OF BIRTH DEFECTS will expand thanks to a $1.85 million grant from the Centers for Disease Control (CDC). Iowa will collaborate with the CDC and the State of California to develop common strategies for collecting data on the families of children born with birth defects. Currently, only the number, type and distribution of birth defects are being tracked.

GENES FOR AN INHERITED EYE DISEASE AND FOR USHER SYNDROME have been located on chromosome 11 by two groups of UI researchers. **Dr. Richard Smith, otolaryngology,** found that multiple genes cause Usher Syndrome Type I after analyzing blood samples from affected and unaffected relatives in eight families descended from the French Acadian population of southwestern Louisiana and from 11 British families. **Drs. Edwin Stone, ophthalmology,** and **Val Sheffield, pediatrics,** have located two genes for eye diseases that can cause blindness. The gene for autosomal dominant neovascular inflammatory vitreoretinopathy (ADNIV), a rare disease, was found on chromosome 11. Information about this disease may yield important clues to other, more common eye diseases with similar characteristics, such as retinitis pigmentosa and diabetic retinopathy. The gene for butterfly-shaped pigment dystrophy of the fovea was found on chromosome 6. This disease shares many similarities with age-related macular degeneration, the most common cause of legal blindness in older individuals.

TWO HUNDRED IOWA WOMEN WILL PARTICIPATE IN A LANDMARK STUDY to see if hormone replacement can reduce a woman's chances of having a heart attack. Heart disease is the leading cause of death among postmenopausal women, but little research has focused on heart diseases in women, says **Dr. Helmut Schrott, preventive medicine and environmental health.** The new study will look at the effect of hormone replacement in reducing subsequent heart attacks in more than 2,000 women with heart disease nationwide.



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BALTIMORE

Cocaine abuse in a high risk obstetrical population

In a sample of high risk pregnancies at the University of Iowa Hospitals and Clinics, a 1.4% prevalence of prenatal cocaine abuse was found, much lower than that in major cities. Clinical judgment should guide the need for testing in low prevalence areas.

Steven Keller, M.D.
Des Moines, Iowa
Jennifer Niebyl, M.D.
Iowa City, Iowa

COCAINE ABUSE IN PREGNANCY has significant medical, legal and ethical implications. There are many documented serious complications from prenatal cocaine use. Its increasing use among reproductive age women warrants thorough investigation.

Various studies have shown that the incidence of cocaine abuse in the general population has increased dramatically over the last decade. This increase has been paralleled by an increase among pregnant women. Within pregnant populations, the reported rate of prenatal use is variable (Table 1).[1-7] Several techniques were used to determine the prevalence in these studies, but we believe these numbers underestimate the actual incidence of abuse. Directed interviews, double interview techniques, random and routine regimented toxicology screens have been employed, but various studies have shown at least a 30% under-reporting of prevalence from interview techniques. Drug screens reflect use in the most recent 24-48 hours.

The purpose of our study was to assess the prevalence of prenatal cocaine abuse in certain high risk patients at University of Iowa Hospitals and Clinics. The patients evaluated were those which in previous studies were found to have the highest risk for prenatal cocaine abuse.

Materials and methods

Eleven different study categories were selected as shown in Table 2. **Preterm contractions** were defined as five or more contractions per hour before 37 weeks and **preterm labor** meant cervical change before 37 weeks. **Spontaneous abortion** included those from 20 to 25 weeks and **premature rupture of membranes** was any rupture of membranes before 37 weeks. **Abruptio placentae** included any suspected or documented abruption. **Drug abuse history** included those with a positive drug abuse history during the current pregnancy. **No prenatal**

Dr. Keller practices in Des Moines and Dr. Niebyl is Professor and Head, Department of Obstetrics and Gynecology, UI College of Medicine.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR APRIL 1993

TABLE 1

JOURNAL REVIEW OF COCAINE ABUSE IN PREGNANCY

Investigator (Journal)	*Year*	*# Patients*	*% Cocaine Use*	*Study Site*
Little, et al.	1988	102	9.8	Dallas
Frank, et al.	1988	679	17	Boston
Amaro, et al.	1989	253	17	Boston
Neerhof, et al.	1989	1776	8	Chicago
Zuckerman, et al.	1989	90	12	Boston
McCalla, et al.	1991	1111	11.5	New York
Reddin, et al.	1991	297	7.1	Des Moines
Present Study	1991	144	1.4	Iowa City

TABLE 2

STUDY GROUP CATEGORIES

Study Group	*# Patients*	*# Positive Screens*
Preterm contractions	31	Opiates (3), THC (1)
Preterm labor	52	Opiates (3), THC (1)
Spontaneous abortion	3	None
Premature rupture of the membranes	28	Opiates (1), THC (2), Amph (1), COCAINE (1)
Abruptio placenta	10	Amph (2), Methamph (1), COCAINE (1)
Drug abuse history	20	Opiates (2), THC (1), Amph (2) Methamph (1), COCAINE (2), Benzo (1)
No prenatal care	9	Amphet (1), COCAINE (1)
Fetal death in utero	5	None
Fetal anomalies	1	THC (1)
Fetal growth retardation	9	Opiates (1), COCAINE (1)
Other	10	Opiates (1), THC (1), Barbit (1)

Total number of patients screened = 144
Total number of positive cocaine screens = 2

care was a category limited to those in their third trimester on initial presentation. **Fetal death in utero** included those intrauterine fetal deaths 20 weeks and above. **Fetal anomalies** included only those with no known genetic cause. **Fetal growth retardation** included both symmetric and asymmetric growth retardation and the **other** category was added to include diagnoses such as abdominal pain of unclear etiology, fever of unknown origin, distant drug abuse history and seizures.

Each patient who came to the labor and delivery suite from June, 1990 until March, 1991 was enrolled if the presenting diagnoses fell into one or more of these categories. The only exclusion factors were multiple gestation and hospitalization for 24 hours or longer immediately before presentation at the University Hospital. A clean catch urine was obtained within 24 hours of admission (usually within 1 to 2 hours) and was sent for routine urine toxicology screen.

The standard drug screen consisted of a panel of drugs of abuse including alcohol, amphetamines, barbiturates, benzodiazepines, opiates, phencyclidine, tetra hydrocannabinol (THC) metabolites and cocaine metabolites. Cocaine was detected using an enzyme immunoassay test with positive results confirmed using a fluorescent polarization immunoassay test.

Results

During the period studied, 144 patients fell into at least one of the study categories. During this time only two cocaine screens were positive and both of these fell into two or more study categories (Table 2). Both patients had a known

drug abuse history before confirmation in the study.

Of note, several other drugs were also detected, although the high number of opiates probably represents primarily iatrogenic administration before urine collection.

Discussion

Sample size for each of the various categories is not large enough for individual statistical analysis. Overall, the incidence of cocaine abuse at University Hospitals appears to be substantially less than across the nation (Table 1). The study population represents those at highest risk for cocaine abuse. One can assume the general rate of cocaine abuse among the entire prenatal population would be lower.

Our cocaine abuse prevalence (1.4%) is also substantially less than the 7.1% reported by Reddin, et al in the study conducted at Broadlawns Medical Center in Des Moines, Iowa.[7] Although different study techniques were used, the main variable probably is the difference between our predominantly rural indigent population and the predominantly urban population at Broadlawns.

Since both patients with positive cocaine screens had a known drug abuse history, we are reassured that our routine prenatal history taking is an effective prenatal drug abuse screen.

Given the low cocaine abuse prevalence at University Hospitals, routine screening is probably not cost-effective. Clinical judgment is still necessary in deciding when to test for cocaine abuse.

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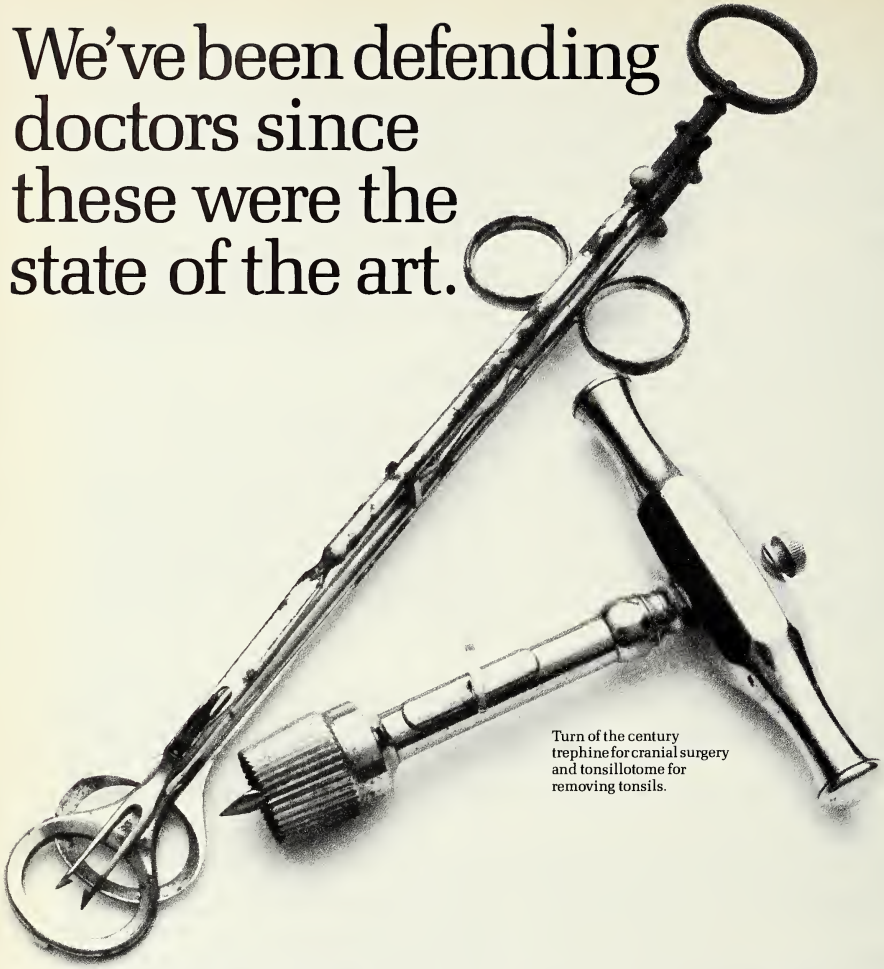
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SuperPRO: an explanation

WHEN CONGRESS ESTABLISHED peer review organizations (PROs) in 1982, it charged the Secretary of Health and Human Services with evaluating the effectivenesss of the PROs. The Secretary developed monitoring and assessment protocols for the Health Care Financing Administration (HCFA) and the PROs. HCFA also established a "SuperPRO" to independently validate the accuracy of medical determinations made by PROs.

In addition to evaluating the PRO's medical determinations, the SuperPRO verifies the appropriate application of the PRO's criteria and the HCFA Generic Quality Screens for referral of cases to physician review.

In 1985, HCFA awarded the SuperPRO contract to SysteMetrics, Inc., a subsidiary of McGraw-Hill to perform review of all 54 PROs. Its subcontractor National Medical Audit is responsible for all external physician review and maintains a national panel of qualified physicians in all relevant specialty and subspecialty areas.

HCFA selects a sample of medical records and provides the SuperPRO and the PRO with a list of the sampled cases. PROs provide copies of the sample cases to the SuperPRO. PRO determinations are not known at the time of the SuperPRO's review.

SysteMetrics reviews approximately 400 Medicare cases for each PRO approximately once a year, using individual PRO's review criteria and physician reviewers. SysteMetrics obtains the PRO's review results for the same cases, compares the two results for the same cases and reports its agreement/disagreement rates to HCFA and the PRO.

Agreement occurs when both SysteMetrics and the PRO approve or disapprove a case; disagreement occurs when SysteMetrics approves a case a PRO disapproved or SysteMetrics disapproves a case a PRO approved. It should be noted that SysteMetrics does not interact with local physicians and doesn't hear attending physicians' explanations before making an adverse review decision.

IFMC's SuperPRO determinations

How has the IFMC fared under SuperPRO review? We've consistently received high agreement rates from the SuperPRO. SysteMetrics' most recent evaluation of the IFMC was completed in June 1992. At that time, review encompassed acute and ambulatory surgery cases.

Of the 217 Prospective Payment System cases reviewed, the IFMC's agreement rates were: 93.5% for DRG validation; 95.9% for admission review; 97.2% for quality of care; and 100% for premature discharge.

SysteMetrics reviewed 195 ambulatory surgery cases. The IFMC's agreement rates were: 93.8% for HCPCS validation; 90.8% for surgical necessity; and 78.5% for quality of care.

(Many of the disagreements represented ambulatory surgery cases in which a history and physical or preoperative note was missing. The SuperPRO identified these as quality concerns; the IFMC did not.)

This article was written by R. Ried Boom, M.D., Chairperson of the Iowa Foundation for Medical Care Comprehensive Review Committee.

IOWA METHODIST MEDICAL CENTER

The Throckmorton Surgical Society and Iowa Academy of Surgery Spring Meetings

April 30-May 1, 1993
Jester Auditorium
Iowa Methodist Medical Center
Des Moines, Iowa

Friday, April 30, 1993: The Throckmorton Surgical Society Symposium on Breast Cancer

Guest Faculty

John M. Bedwinek, M.D.
Director, Radiation Oncology
St. Joseph's Hospital Cancer Center
St. Louis, Missouri

Blake Cady, M.D.
Professor of Surgery
Harvard Medical School
Chief of Surgical Oncology
New England Deaconess Hospital
Boston, Massachusetts

Frank E. Gump, M.D.
Chief, Surgical Service
Department of Veterans Affairs
Professor of Surgery
UMDNJ/New Jersey Medical School
East Orange, New Jersey

Peter R. Jochimsen, M.D.
Professor, Surgery
University of Iowa College of Medicine
Director, Surgical Oncology
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Karl G. Kardinal, M.D.
Ochner Clinic
New Orleans, Louisiana

Richard J. Field, M.D.
General Surgeon
Centreville, Mississippi

Topics

- *Postmastectomy Irridation: What is Its Role Today?*
- *Limitations of Mammographic Screening*
- *Breast Conservation Surgery: Patient Selection*
- *Treatment of Noninvasive Breast Cancer*
- *Contemporary Therapy of Early Breast Cancer*
- *Management of the High Risk Breast Patient*
- *Tamoxifen Breast Cancer Prevention Trial*
- *Pitfalls of Needle Localization and Sterotactic Techniques*
- *Rationale for and Status of the NSABP Prevention Trial*
- *Management of Locally Advanced and Inflammatory Breast Cancer*
- *Update on Adjuvant Therapy of Breast Cancer*
- *Surgery in Rural America*

Saturday, May 1, 1993: Iowa Academy of Surgery Meeting

Speakers

William W. Eversmann, Jr., M.D.
President, Iowa Medical Society
Orthopedic Surgeon
Cedar Rapids, Iowa

Roger D. Tracy
Assistant to the Dean/Director,
Office of Community-Based Programs
University of Iowa Hospitals and Clinics
Iowa City, Iowa

Daniel K. Zismer, Ph.D.
Principal, Director and Co-Founder
of Partners Consulting Group, Ltd.
Minneapolis, Minnesota

Topics

- *Presentation of Resident Competition Papers and Awards at the Scientific and Clinical Session*
- *The Future of Health Care Reform in Iowa: Where is Iowa Going?*
- *The Future of Rural Medical Care in Iowa*
- *Hospital-Physician Relationship in the '90s*
- *Panel Discussion: Where is the Solo Physician Going? Crystal Ball Predictions*

FEES: Physicians $150.00
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As an organization accredited for Continuing Medical Education, the Iowa Methodist Medical Center certifies that this CME program meets the criteria in Category 1 of the Physicians Recognition Award of the AMA.

Community CME and the University

Richard Nelson, M.D.

THE FAMILIAR CONFERENCE MODE for CME has been perfected in many academic medical centers. Courses are planned for one or more days; faculty are scheduled for presentations in their areas of expertise; participants register and attend. This format has many attractions. Practitioners from diverse communities are able to break away from their routines and concentrate their energies on continuing education. Multiple faculty are accessible for constructing a broad-based learning experience.

University faculty often prefer this format since it minimizes their time commitment and necessitates no travel. Yet other faculty have found that developing a community-based CME experience presents a more personal opportunity to interact with community physicians and other health care professionals.

Perhaps the first community CME of this type in Iowa occurred in association with the traveling consultation clinics of the State Services for Crippled Children, a University of Iowa service program (now the Child Health Specialty Clinics). Faculty physicians and other personnel over many years journeyed during the preceding day to the community that was to host the clinic and would lecture to community physicians during that evening or early during the following morning. Perhaps it was a less complex time, but these sessions were generally well-attended despite adverse weather and other potential conflicts.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

This model gradually became less practical as time constraints emerged for both the community physician and the faculty. In its place a more focused approach developed, usually in relation to specific patient populations. A noteworthy example is the Iowa Perinatal Program, a joint effort of the University of Iowa and the Iowa Department of Public Health. In this program a faculty perinatologist and a neonatologist periodically visit community hospitals to review perinatal medical records. Exemplary practice and adverse outcomes are noted and an educational session is scheduled with physicians and hospital staff. This highly specific practice feedback is valued and, if the state's declining infant mortality is a measure, effective in improving practice.

'We have established an application program in the College of Medicine to provide support funds to faculty who plan and conduct CME events in Iowa communities.'

During the current year we have established an application program in the College of Medicine to provide support funds to faculty who plan and conduct CME events in Iowa communities. We hope these monies can cover expenses (such as travel and local arrangements) that deter many faculty from "hitting the road." The application is competitive, but we will assure that programs of importance reach Iowa communities.

Hospital ethics committees

Robert Weir, Ph.D.

THE CONCEPT OF A HOSPITAL ETHICS committee (HEC) can be traced back to the late 1970s. The original rationale combined (1) the benefits of collective decision making with (2) the desire for greater objectivity in decision making in difficult clinical cases and (3) the need to enhance the participation of patients/surrogates in cases having difficult ethical choices.

The idea of HECs gained considerable popularity in the 1980s. The President's Commission for the Study of Ethical Problems in Medicine (1980-1983) and the Department of Health and Human Services recommended all hospitals establish such committees. By 1986, a survey conducted by the American Academy of Pediatrics indicated more than 60% of the nation's hospitals had HECs.

Along the way, the original rationale for ethics committees has been broadened. Most persons who have experience with ethics committees now agree that HECs have three important functions: (1) to carry out educational activities regarding biomedical ethics for committee members, the medical staff, the nursing staff, other health professionals in the institution, patients and the families of patients; (2) to draft and propose relevant institutional policies (e.g., abating life-sustaining treatment, DNR decisions, use of advance directives, the determination of patient decision making capacity, the neurological determination of death); and (3) to consult on problematic cases when asked to do so by the attending physician, a nurse or a social worker on the case, the patient or the patient's family.

In each of these ways, an HEC can make important contributions to a hospital. In addition, an HEC:

- can be an institutional mechanism that promotes continuous quality improvement in the provision of patient care
- can be a tool of risk management by providing an in-house locus for the resolution of some patient and surrogate concerns
- can provide moral support and advice to physicians as they grapple with difficult decisions
- can provide clarification of facts in a difficult case by getting all the medical consultants together in a room at the same time, in an atmosphere of candor, to discuss the case
- can be an institutional mechanism of quality control through its drafting of institutional policies, its efforts to educate the staff regarding ethics-oriented policies and its monitoring of such policies
- can address ethical concerns on the part of the medical and nursing staff
- can, given the varied experiences and collective wisdom represented by its members, come up with new ideas for handling difficult cases or situations
- can be a cost-effective mechanism by cutting legal expenses incurred when some patients/families vent their frustration by taking legal action against the hospital.

Next time we will discuss the membership of HECs, discuss some possible problems that can arise with ethics committees and indicate how ethics committees are changing in the 1990s.

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.



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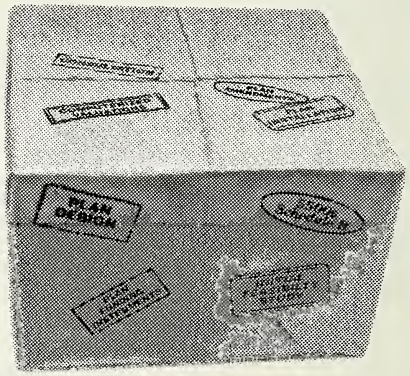
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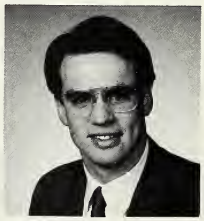
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William Eversmann, Jr., M.D.

More dishonesty

PHYSICIANS, MORE THAN ANY other group, know that health care reform is necessary. Physicians have been part of the Iowa Leadership Consortium and are involved in the Governor's Health Care Reform Council.

Unlike the state, the federal government has enjoyed the luxury of dishonesty in the purchase of health care by allowing their sponsored programs to be paid for in part by cost shifting from private insurance. It seems unlikely this unenviable record of overselling and underfinancing will change with a health care reform package conceived in secret.

We have witnessed the media events, one as close as Ankeny, and we have seen the pharmaceutical companies bashed by Mr. Clinton.

How then should we analyze the Clintons' plan? First, look at the plan's cost containment. There will be several provisions but they will fall into two larger categories: those which will control costs in the future and those that will affect immediate cost reductions. The long range controls will include insurance reform, single claim form, tort reform (if any), reduced administration and community health alliances (WJC—new name for managed competition).

The immediate cost reductions will include provider taxes, price fixing, mandatory price reductions or expansion of Medicare fee schedules to private insurance.

Second, we must remember the Clintons have controlled the entire process. Organized medicine has had no control and no formal contribution to the reform plan. We have not "bought in" to the plan. We need not accept responsibility for its creation.

Even the German and Canadian systems of health care delivery were conceived with the cooperation of health care providers.

Price control is a quick fix that hasn't worked in Great Britain, Canada, Germany or Japan. This short term solution will further alienate the medical profession, which is already concerned over being excluded from developing a health care reform plan. Confrontation is likely, even inevitable. Let us be sure the public is well informed regarding the effect the Clinton plan will have on health care delivery so their support can be maintained. Be certain the Iowa Medical Society will keep you informed.

This is my final column as IMS president and I leave this space in the very capable hands of my successor, Jack Anderson. I thank everyone for their support during the past year.

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INTENDED AUDIENCE:

Cardiologists, internists, and family practitioners who deal with cardiovascular disorders.

SYMPOSIUM DESCRIPTION:

Cardiology '93 at the Bix is the third annual cardiovascular symposium of St. Luke's Regional Heart Center. An outstanding national faculty has been assembled to present a concise update on the ever-changing field of cardiovascular medicine. Participants will acquire clinical insight into diagnostic and treatment modalities.

ACCREDITATION:

CME: St. Luke's Hospital is accredited by the Iowa Medical Society to sponsor continuing medical education for physicians. St. Luke's Hospital designates this CME offering meets the criteria for 6.5 hours in Category I of the AMA Physician's Recognition Award.

AAFP: This program has been reviewed and is acceptable for 6.5 prescribed hours by the American Academy of Family Physicians.

REGISTRATION INFORMATION:

Registration Fee: $95 includes attendance at the symposium, two free tickets for the Friends of Bix' Cocktail Party, 2 complimentary tickets for the Riverboat Gambling Cruise and 2 entries in the Bix 7 Road Race.

Registration Deadline: July 1, 1993. Confirmation and details about entertainment options will be sent upon registration. Please direct any concerns to Rebecca Gannon(319) 326-8115. Refund policy: A refund less a $25.00 processing fee if your request is postmarked by July 15, 1993.

MORNING SCHEDULE

8:00- 8:20	Registration-Continental Breakfast
8:20- 8:35	Welcome - Symposium Overview - Dr. Giudici
8:35- 9:15	"Lipid Disorders" Dr. Connor
9:15- 9:55	"Advances in the Treatment of Atrial Fibrillation/Flutter" Dr. Waldo
9:55-10:20	Break
10:20-11:00	"Renal Implications and the Treatment of Essential Hypertension" Dr. Gratch
11:00-11:40	Panel
11:40-12:55	Lunch with the Speakers

AFTERNOON SCHEDULE

12:55- 1:35	"Management of Ventricular Arrhythmias" Dr. Wilber
1:35- 2:15	"New Techniques in Interventional Cardiology" Dr. Fischman
2:15- 2:35	Break
2:35- 3:15	"Non-Invasive Cardiology Update" Dr. Miller
3:15- 3:55	Panel

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The Editor Comments



Marion E. Alberts, M.D.

Don't ingest it, don't touch it, don't breath

IT IS UNDERSTANDABLE THE public may be confused about the preservation of good health. From many sources come admonitions that this or that may be detrimental. Various substances we ingest, touch or breath may have, according to "reliable sources," detrimental effects on the recipient.

But, are those sources truly "reliable?" Are the conclusions from their data valid? Are self-serving "scientists" promoting conclusions in order to perpetuate grants to promote "research" that may be biased or prejudicial at the onset? There are many questions that need scientifically correct answers.

Much data which supposedly "prove" an invalid conclusion are based upon the inappropriate logic of **post hoc ergo hoc.** Sometimes that false logic is as illogical as a statement I read recently: "The number of storks in Germany has been decreasing for decades. At the same time the German birth rate also has been declining. Aha! Solid evidence that storks bring babies!" The article by Dr. Bruce Amos (Science and the environment: facts vs phantoms, *Priorities for Long Life and Good Health,* Winter 1993, pp. 42-43) makes a plea for a future where environmental policy will be based on science and knowledge rather than unjustified speculation and alarmism.

There is common misconception with regard to cancer tests . . . that high dose animal cancer tests indicate significant cancer risks for humans. So many test substances used on animals have been demonstrated to be carcinogenic; but, these tests are conducted at near toxic levels chronically administered. Obviously the high dose rather than the chemical is the risk factor.

Further, there is often an implication that synthetic chemicals are a major problem. Many plants produce natural pesticides; of all dietary pesticides, over 99% are natural. It has been estimated that we ingest roughly 5,000 to 10,000 natural pesticides and their breakdown products. An estimated 1,500 mg of natural pesticides are ingested per person per day, about 10,000 times more than consumed of synthetic pesticide residues.

Some will refute these statistics. However, the point is we physicians must be wise in our discussions with patients regarding their concerns over harm from things injested, touched or breathed. We must measure truth based on accurate unbiased scientific knowledge against phantom data promoted by environmentalists who find fault with nearly everything except their own concepts.

Clinton staff is listening, but health care reform plan remains a mystery, says AMA trustee

DOCTORS HAVEN'T BEEN "COMPLETELY locked out" of the Clinton administration health care reform process, and the AMA plans to keep its foot in the door as long as possible, Dr. Nancy Dickey, AMA trustee, told a group of nearly 200 Iowa physicians at a March 30 seminar in Des Moines.

Dr. Dickey was a keynote speaker at a special program entitled *Iowa health care delivery . . . what form will it take?* sponsored by IMS Services. The program, put on for specialty societies affiliated with the IMS, featured updates on health care reform from a number of experts.

The AMA has been excluded from Mrs. Clinton's health care reform task force, related Dr. Dickey, because it is a special interest group.

"Yes, we are a special interest group, and our special interest is our patients," she added.



Nancy Dickey, M.D. AMA Trustee

AMA will keep the door open

Dr. Dickey said AMA representatives have had several "cordial conversations" with Ira Magaziner, the head staff person for President Clinton's health care reform project. Key topics for discussion were the need for liability reform to help control costs and regulations that interfere with the practice of medicine without improving quality of care. The meetings with Mr. Magaziner, she said, will continue.

"We're going to keep that dialogue going as long as possible," she stressed. "We will take every opportunity offered to us by the Clinton administration."

Though a health care reform blueprint was scheduled to be unveiled early this month, Dr. Dickey expressed concern that there are very few clues as to what it will contain. During another portion of the March 30 program, she questioned Dr. Stephen Gleason, a member of the Clinton health care transition team. Dr. Gleason spoke to the group via the telephone.

"Everyone in the Clinton administration keeps saying there is a lot of work to do on the plan, yet they are still scheduled to put something on the table in early May. Do you have enough specificity to meet this deadline?" she asked Dr. Gleason.

Dr. Gleason said the plan will be a "strong framework" but there will be a lot of room for discussion and refinement.

So far, details not forthcoming

Dr. Dickey also discussed the late March Washington "fly-in" involving 1,000 physicians.

"We heard from both sides of the aisle in Congress and every one of them talked about the need for liability reform and preservation of choice," she reported. However, she expressed concern that very little is being said about the details of the final proposal.

"They're listening, but they're giving us very little meat to respond to," she commented. "Physicians have a fair amount of

clout, though, as Vice President Gore suggested, not as much as we once had."

Dr. Dickey warned physicians to guard against "letting them pass a health care reform proposal in secret. They may try to get something through very quickly. We must be sure we thoroughly analyze any proposal. Let your congressmen know what it will mean for your patients now and in the future."

Choice must be maintained

Dr. Dickey stressed that any health care reform must maintain choice for patients and physicians and said the AMA is very concerned that costs are shaping the debate rather than quality and access considerations. She also expressed the hope that health care reform will include some sort of antitrust relief and insurance reform.

"Doctors are everybody's favorite scapegoat," she said. "We're being held responsible for a lot of things we have no opportunity to change. We didn't create the societal problems of violence, drugs, AIDS or teen pregnancy, we created the technology to cope with them."

Dr. Dickey said that capping expenditures would not be an effective approach to cost control. Rather, patients and physicians must be given incentives to consider the cost and necessity of various treatments.

"I don't want us to be the ones slamming the door on patients, even if liability considerations are taken away," she told the Iowa group. "Patients have to be a part of this."

An exciting time for medicine

Physicians have known for a long time that the system needs reform, Dr. Dickey said.

"This is both a frustrating and exciting time for us," she concluded. "This reform will define our profession for years to come. We must be able to say we were part of the process."



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Poll reflects sick society

Mike Royko

Note: This article is reprinted with permission from Tribune Media Services.

ON A STUPIDITY SCALE, a recent poll about doctors' earnings is right up there. It almost scored a perfect brain-dead 10.

It was commissioned by some whiny consumers group called Families USA.

The poll tells us that the majority of Americans believe doctors make too much money.

The pollsters also asked what a fair income would be for physicians. Those polled said, oh, about $80,000 a year would be OK.

How generous. How sporting. How stupid.

Why is this poll stupid? Because it is based on resentment and envy, two emotions that ran hot during the political campaign and are still simmering.

You could conduct the same kind of poll about any group that earns $100,000-plus and get the same results. Since the majority of Americans don't make those bucks, they assume that those who do are stealing it from them.

Maybe the Berlin Wall came down, but don't kid yourself, Karl Marx lives.

It's also stupid because it didn't ask key questions, such as: Do you know how much education and training it takes to become a physician?

If those polled said, no, they didn't know, then they should have been disqualified. If they gave the wrong answers, they should have been dropped. What good are their views on how much a doctor should earn if they don't know what it takes to become a doctor?

Or maybe a question should have been phrased this way: "How much should a person earn if he or she must (a) get excellent grades and a fine educational foundation in high school in order to (b) be accepted by a good college and spend four years taking courses heavy in math, physics, chemistry and other lab work and maintain a 3.5 average or better, and (c) spend four more years of grinding study in medical school with the third and fourth years in clinical training, working 80 to 100 hours a week, and (d) spend another year as a low-pay, hard-work intern, and (e) put in another three to 10 years of post-graduate training, depending on your specialty and (f) maybe wind up $100,000 in debt after medical school and (g) then work an average of 60 hours a week, with many family doctors putting in 70 hours or more until they retire or fall over?"

As you have probably guessed by now, I have considerably more respect for doctors than does the law firm of Clinton and Clinton, and all the lawyers and insurance executives they have called together to remake America's health care.

Based on what doctors contribute to society, they are far more useful than the power-happy, ego-tripping, program-spewing, social tinkerers who will probably give us a medical plan that is to health what Clinton's first budget is to frugality.

But propaganda works. And, as the stupid poll indicates, many Americans wrongly believe that profiteering doctors are the major cause of high medical costs. Of course doctors are well compensated. They should be. Americans now live longer than ever. But who is responsible for our longevity—lawyers, Congress, or the guy flipping burgers in a McDonalds?

(Continued on page 181)

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Bruce M. McGehe
Des Moines, Iowa

And the doctors prolong our lives despite our having become a nation of self-indulgent, lard-butted, TV-gaping couch cabbages.

Ah, that is not something you heard President Clinton or Super Spouse talk about during the campaign or since. But instead of trying to turn the medical profession into a villain, they might have been more honest if they had said:

"Let us talk about medical care and one of the biggest problems we have. That problem is you, my fellow American. Yes, you, eating too much and eating the wrong foods; many of you guzzling too much hooch; still puffing away at $2.50 a pack; getting your daily exercise by lumbering from the fridge to the microwave to the couch; doing dope and bringing crack babies into the world; filling the big city emergency rooms with gunshot victims; engaging in unsafe sex and catching a deadly disease while blaming the world for not finding an instant cure.

"You and your habits, not the doctors, are the single biggest health problem in this country. If anything, it is amazing that the docs keep you alive as long as they do. In fact, I don't understand how they can stand looking at your blubbery bods all day.

"So as your president, I call upon you to stop whining and start living cleanly. Now I must go get myself a triple cheesy-greasy with double fries. Do as I say, not as I do."

But for those who truly believe that doctors are overpaid, there is another solution: Don't use them. That's right. You don't feel well? Then try one of those spine poppers, needle twirlers, or have Rev. Bubba lay his hands upon your head and declare you fit.

Or there is the do-it-yourself approach. You have chest pains? Then sit in front of a mirror, make a slit here, a slit there, and pop in a couple of valves.

You're going to have a kid? Why throw your money at that overpaid sawbones, so he can buy a better car and a bigger house than you will ever have (while paying more in taxes and malpractice insurance than you will ever earn)?

Just have the kid the old-fashioned way. Squat and do it. And if it survives, you can go to the library and find a book on how to give it its shots.

By the way, has anyone ever done a poll on how much pollsters should earn?

IPMIT merger approved by policyholders

PHYSICIAN POLICYHOLDERS OF IOWA Physicians Mutual Insurance Trust approved a merger with Midwest Medical Insurance Company (MMIC) at a special member/policyholder meeting April 1. The results of the policyholder vote were announced to IPMIT members and policyholders on that date.

Though the exact timetable for the merger has not been determined, IPMIT and MMIC officials hope the merger will be completed early this summer.

Sound protection, reasonable cost

"IPMIT insureds will continue to have sound liability protection at a reasonable cost," commented Dennis Walter, M.D., chairman of the IPMIT Board of Directors. "MMIC, like IPMIT, is a company controlled, directed and owned by physicians to serve physicians' interests."

The IPMIT Board of Directors approved an intent to merge with MMIC—a physician controlled company founded by the Minnesota Medical Association—early last summer. IPMIT board members said the move is in the best interests of IPMIT physicians because it will convert IPMIT into a well capitalized regular company rather than an assessable mutual. The merged company will be nearly four times the size of IPMIT.

Details of merger

- The merged company (MMIC) will provide professional liability insurance to all IPMIT insureds and to qualifying members of the Iowa Medical Society.
- Iowa physicians insured with IPMIT will have proportional representation on the MMIC Board.
- Present Iowa defense counsel will continue to represent Iowa physicians.
- Many of the Iowa insurance operations and employees will remain in the IMS headquarters building in West Des Moines.
- Iowa physicians will continue their involvement in Iowa claims and underwriting committees.
- IPMIT policyholders will be receiving more information in the near future regarding specifics of coverages and means of service, Dr. Walter said.

(Continued next page)

Doctors' Day donation

FUNDS GENERATED IN HONOR of Doctors' Day totalling $915.00 will go to AMA-ERF (American Medical Association Education and Research Foundation). Following are the names of those physicians and groups who were honored:

Dr. James Bell, Des Moines
Dr. Bruce Trimble, Mason City
Dr. Dean Ehrecke, Le Claire
Dr. Philip Habak, Bettendorf
Dr. Fred Carpenter, Jr., Newton
Dr. John Anderson, Boone
Dr. Dallas Minchin, Council Bluffs
Dr. Paul Holzworth, Des Moines
Dr. Ronald Moeller, Mason City
Dr. Larry Beaty, Des Moines
Dr. B.E. Hoenk, Bettendorf
Dr. Dwayne Howard, Fort Meyers, Florida
Dr. David Howard, Sioux City
Dr. Thomas Johnson, Ames
Mercy Hospital, Davenport
Webster County Auxiliary, Fort Dodge

Broad-based program planned for 1993 Advisory Committee Symposium June 10 and 11, 1993

THE COMMISSIONER'S WORKERS' Compensation Advisory Committee has announced that the 1993 Symposium will be held on Thursday and Friday, June 10 and 11, 1993 at the Hotel Fort Des Moines.

The program will feature individual and panel presentations by Commissioner Orton, the Commissioner's office and experts and doctors from numerous disciplines. Comp reform, medical cost containment, risk management and overview of recent cases, legislation, the ADA and expedited hearings will be discussed with audience participation encouraged. Medical topics will include endoscopic carpal tunnel treatment, a critique of MRIs and CTs and testing for low back dysfunction.

For registration information, contact Sharon Downen, telephone 515/281-8335.

About IMS Members

New members (as of March 18, 1993)

John Bennett, M.D., internal medicine, Mt. Pleasant
Dale Armstrong, M.D., child psychiatry, Fairfield
Michael Greiner, M.D., family practice, Fairfield
H. Culver Boldt, M.D., vitreoretinal, Iowa City
Gerald Jogerst, M.D., family practice/geriatrics, Iowa City
William Mathers, M.D., ophthalmology, Iowa City
Lynn Skopec, M.D., pathology, Iowa City
Robert Spector, M.D., ophthalmology, Iowa City
Lisa Benson, M.D., resident, Iowa City
Paul Johnson, M.D., resident, Iowa City
Michael Moore, M.D., resident, Iowa City
Donald Wothe, M.D., resident, Iowa City
Gregory Bohn, M.D., general surgery, Davenport
Scott Samelson, M.D., general surgery, Davenport
Mark Dion, M.D., radiation oncology, Dubuque
Diane Sorenson, M.D., internal medicine, Dubuque
Brad Janson, M.D., radiology, Mason City
Jeffrey Wilwert, D.O., family practice, Oelwein
Michael Smith, M.D., general surgery, Waterloo
J. Timothy Aldridge, M.D., internal medicine, Nevada
John McKee, M.D., neurology, Ames
Steven Keys, M.D., pediatrics, Ottumwa
Thomas Becker, M.D., pediatric cardiology, Des Moines
Garry Goodlett, M.D., family practice, Indianola
Thomas McAuliff, D.O., pediatrics, Des Moines
Theresa Wahlig, M.D., pediatrics/neonatology, Des Moines
James Wile, M.D., anesthesiology, Des Moines
Kevin Emge, D.O., obstetrics/gynecology, Des Moines
Ben Crouse, M.D., family practice, Logan
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Julie Fabregas-Schindler, D.O., family practice, Denison
Alexander Pruitt, M.D., orthopedics, Spencer
Gregory Hoversten, D.O. family practice, Sioux City
Bruce Miller, M.D., cardiology, Sioux City
Pascuala Reyes, D.O., family practice, Sioux City

Deceased members

James Bishop, M.D., 82, life member and past IMS president, surgery, Davenport, died March 4
Wade Preece, M.D., 96, life member, general surgery, Waterloo, died March 4
Urban Collignon, M.D., 78, internal medicine, Santa Fe, New Mexico, died March 28
Thomas Pauly, M.D., 48, plastic surgery, Cedar Rapids, died March 2
Samuel Leinbach, M.D., 85, life member and past IMS president, family practice, Belmond, died March 10.

Miscellaneous

Michael Giudici, M.D., Davenport, recently presented the abstract "Permanent Right Ventricular Outflow Tract Pacing Improves Cardiac Output — Comparison with Apical Lead Placement" at the 42nd annual scientific session of the American College of Cardiology in Anaheim, California.
David Stilley, M.D. has been named director of the emergency department and urgent care center at Broadlawns Medical Center, Des Moines.
Joseph Buckwalter, M.D., Iowa City, has been elected to the Board of Directors of the American Academy of Orthopaedic Surgeons.

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Policy regarding HIV-infected health care workers

On recommendation of the Iowa Medical Society Committee on AIDS, chaired by John Olds, M.D., the IMS Executive Council directed that the membership be apprised of the policy and procedures of the Iowa Department of Public Health (IDPH) for the control of nosocomial transmission of HIV infection. This action was in response to a 1992 House of Delegates resolution charging the committee to make recommendations regarding a policy on HIV-infected health care workers.

The IDPH policy is consistent with the policies of the AMA and the Infectious Diseases Society of America, said Dr. Olds.

THE IDPH policy is as follows:

IOWA DEPARTMENT OF PUBLIC HEALTH
Policy on HIV/HBV Infected Health Care Workers

The Iowa Department of Public Health has formulated the following guidelines to comply with the Centers for Disease Control (CDC) Recommendations for Preventing Transmission of Human Immunodeficiency Virus (HIV) and Hepatitis B Virus (HBV) to Patients During Exposure-Prone Procedures. These guidelines also fulfill requirements of federal legislation that all states comply with the Centers for Disease Control recommendations or be ineligible to receive assistance under the Public Service Act.

The proposed Iowa law requires that all hospitals, health care facilities and the Iowa Department of Public Health adopt procedures to evaluate Health Care Workers (HCWs) infected with HIV/HBV who perform exposure-prone invasive procedures. HCWs in the hospital setting should be evaluated by an expert review panel established by the hospital. HCWs in a health care facility or in practice outside the hospital should be evaluated by an expert review panel established by the Iowa Department of Public Health.

It is recommended that all HCWs who are at risk of HIV or HBV infection be tested voluntarily in order to know their antibody status. HCWs who are infected with HIV or HBV (and are HbeAg positive) should not perform exposure prone procedures unless they have sought counsel from an expert review panel and been advised under what circumstances, if any, they may continue to perform these procedures.

The Director of Public Health will choose representatives from various organizations to serve on the Department expert review panel. The composition of the panel at a minimum should include:

1. The infected HCW's personal physician
2. An expert in the same specialty as the infected HCW
3. An infectious disease specialist
4. An infection control specialist
5. The State Epidemiologist from the Iowa Department of Public Health as chairperson

The Iowa Dental Association, Iowa Medical Society, Iowa Osteopathic Medical Association, University of Iowa Hospitals and Clinics Statewide Epidemiology Education and Consultation program in consultation with the Statewide Infection Control Program and Iowa Nurses Association will be requested to submit 1 or 2 names from which the Director of Public Health will choose individual panel members.

The following guidelines are suggested for expert review panels to follow in comply-

ing with recommendations of the Centers for Disease Control:

1. Infection with HIV/HBV alone does not constitute a cause to limit the professional practice of a HCW.
2. Confidentiality must be maintained.
3. Major emphasis should be placed on compliance with universal precautions and other methods of infection control.
4. Recommendations concerning practice modifications and whether or not to require notification of patients should be made on a case by case basis.
5. Other considerations:
 a. technical skill of HCW
 b. mental and physical health of HCW
 c. degree of risk of procedure being performed
 d. frequency procedure is being performed
6. If the infected HCW does not comply with recommendations of the expert review panel, the infected HCW shall be notified and a report made in writing to the appropriate licensing board.
7. The infected HCW may be reviewed by the State review panel, if requested, regardless of local review panel availability.
8. The expert review panel will be responsible for establishing a system to monitor compliance of the infected HCW on a case by case basis. The system shall do all that is reasonably possible to insure that confidentiality is maintained.
9. Each expert review panel shall be responsible for reporting the number of evaluations performed and the number of non-compliant cases to the Director of the State Health Department by January 30 of each year.

Monitoring compliance of the infected HCW should be done by a person with opportunity to observe the infected HCW and knowledgeable about universal precautions and procedures performed by the infected HCW. The responsibility for monitoring falls on the local review panel and the affected HCW. The process should not be obtrusive, and if possible, the infected HCW should participate in its design. The monitor should report non-compliance immediately to the review panel who will then consider reporting to the appropriate regulatory agency.

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Massasauga rattlesnake bites in Iowa

Historically, bites from swamp rattlesnakes in Iowa have been mild, but a bite in eastern Iowa in 1990 produced life threatening thrombocytopenia. Only four populations of massasauga rattlesnakes have been verified in Iowa.

James Christiansen, Ph.D.
Des Moines, Iowa

John Fieselmann, M.D.
Iowa City, Iowa

WE HAVE VERIFIED FOUR envenomations by eastern massasauga rattlesnakes, also called swamp rattlesnakes *(Sistrurus catenatus catenatus)*. Even though this is one of Iowa's rarest poisonous snakes, it is found frequently enough to be of concern to physicians in southern and eastern Iowa.[1] This paper identifies features of the snake, examines the conditions producing the four bites we review and presents a case history of a recent serious bite. The paper reviews treatment for bites from this species.

Identifying massasauga rattlesnakes

Massasauga rattlesnakes are distinguished from Iowa's other two rattlesnake species by their small size (usually less than 30 inches long) and three large scales (plates) between the eyes.[2] Iowa's larger rattlesnakes have granular scales between the two large supraocular scales. The dorsum of the snake has a single row of large black or brown spots, sometimes reddish brown on snakes that have just shed their skin (Figure 1). The background is gray or light brown.



Figure 1. One of two eastern massasauga rattlesnakes found beneath a stock watering tank 150 feet from a woodpile where a rattlesnake bite occurred eight years earlier (*Case 2*).

Dr. Christiansen is with the Drake University Department of Biology; Dr. Fieselmann is with the University of Iowa Department of Internal Medicine.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR MAY 1993

Massasaugas and other pit vipers (family Crotalidae) differ from harmless snakes in having two enlarged hollow fangs, heat sensitive pits between the nostril and eye and elliptical rather than round pupils. The postanal (subcaudal) scales are entire, not divided into two rows, except for those near the rattle. The small flattened rattle or blunt "button" is always present on rattlesnakes.

Massasaugas occupy marshy habitats but we have found that Iowa specimens often move to high ground adjacent to marshes during the summer. They return to the marshes in winter where they hibernate, often in crayfish burrows.[3]

Timber rattlesnakes, the most abundant rattlesnakes in Iowa, are found almost exclusively in areas near rocky outcrops. Rocky outcrops and timber rattlesnake populations are unknown in the regions where the massasauga bites reported in this paper occurred. Prairie rattlesnakes are limited to a small population north of Sioux City.

Massasaugas probably existed in marshes and river floodplains throughout the southern and eastern two tiers of Iowa's counties (Figure 2). Extensive sampling has been unable to verify their continued existence in several localities from which specimens had been taken before 1945. However, rumors persist of their existence in many parts of the range shown. Specimens from the four populations shown in Figure 2, including those mentioned in this paper, are available for examination in the Drake University research collection.

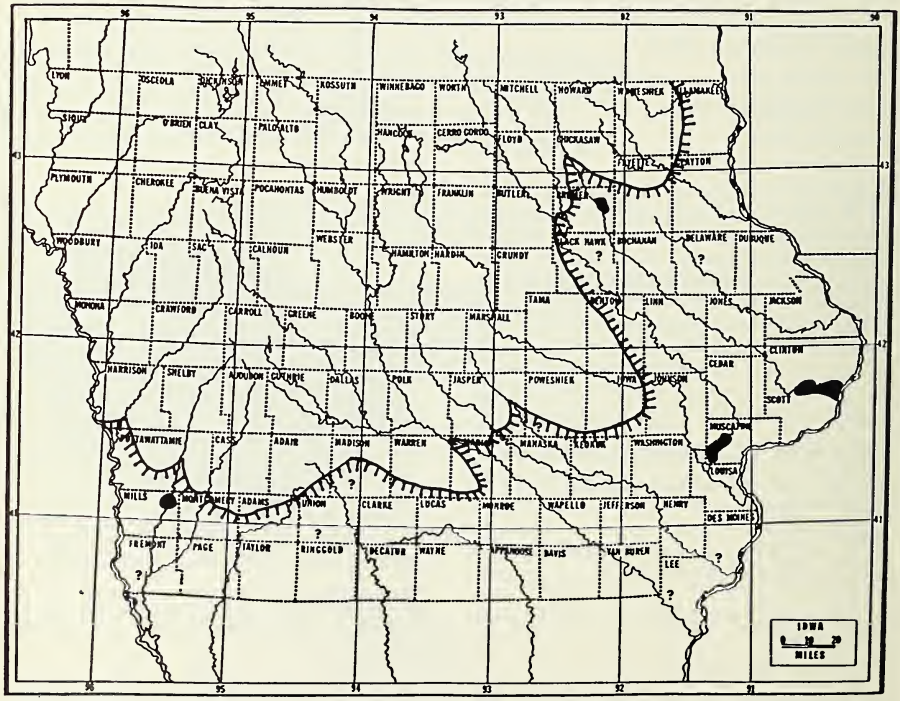


Figure 2. Suspected historic and verified present distributions of massasauga rattlesnakes in Iowa. Darkened areas show locations of known, existing populations; question marks indicate verified localities of populations that may be extinct. Ancestral populations probably existed throughout the indicated area of southern and eastern Iowa.

Conditions leading to bites

All the bites occurred in marshes in eastern Iowa or in habitats adjacent to these marshes. The conditions resulting in the bites are summarized as follows:

Case 1. In April of 1960, a young male had been collecting animals in a marsh near Conesville, Iowa. While resting on a log, he apparently touched a snake he had not noticed and it bit him on a finger. Experienced in snake identification, he recognized the snake as a massasauga and later published the initial symptoms of the bite from this encounter.[4] This species has since been observed frequently and several have been collected from this locality. No other poisonous snakes have been seen there.

Case 2. In 1982, a teenage male was removing wood from a woodpile behind his house on the edge of a marshy floodplain of the Wapsipinicon River when he was bitten on the hand by a snake he believed to be a rattlesnake. Symptoms reported by his father were compatible with massasauga bite.

In 1990, after interviewing the subject's father, the senior author and his students surveyed the farmyard for snakes. In addition to finding approximately 10 fox snakes, a species that superficially resembles massasaugas, they located two massasaugas under an overturned cattle tank about 150 feet from the woodpile where the bite had occurred eight years earlier. (We should point out that the carefree attitude resulting from finding so many similar harmless snakes almost produced another case history for this paper.)

Case 3. In September 1982, a 24-year-old male was bitten on a finger while looking for a lantern in a darkened garage east of Nichols. The snake was reported as a timber rattlesnake, but extensive surveys in that area have failed to yield timber rattlesnakes. We have obtained massasaugas from about 2.5 miles northeast and one mile southeast of the site of the bite. A complete case history was consistent with massasauga bite.

Case 4. On August 24, 1990, a 61-year-old female was bitten on a finger while working in her garden. Her description of the snake as small with reddish brown spots is consistent with some massasaugas that have recently shed. Her husband reported finding a shed skin on the walkway near the garden the same day. Massasaugas were collected within one mile of this locality in identical habitat.

Case histories wanted

The authors are preparing a summary of all venomous snake bites that have occurred in Iowa in the last 50 years and would greatly appreciate receipt of any case histories or other information regarding bites of this or any other venomous species within the state.

Please send the information to Dr. John Fieselmann, Department of Internal Medicine, College of Medicine, University of Iowa, Iowa City, Iowa 52242.

Analysis of the bites

Three of the four bites involved penetration by both fangs and the fang wounds were 1 cm apart in the two that were measured. The first three produced mild to moderate envenomation but the fourth was severe. All involved almost immediate pain, a small amount of bleeding and swelling of the bitten finger or hand within minutes. In all instances except the first, swelling is known to have progressed to the upper arm within five hours of the bite. The report of the first bite makes no mention of swelling beyond the hand.[4]

All bites were reportedly treated with antivenin and all patients recovered after hospital stays of two to four days. Bite number 2 was not treated until the second day. At that time, persistent swelling and ecchymosis of the bitten hand and arm and a sense of acute illness resulted in hospitalization and treatment. The patient was treated with antivenin and released after two or three days.

Bite number 4 was clearly life threatening and may have been fatal had it not been treated. The 61-year-old female came to the University of Iowa Hospitals approximately one hour after being bitten on the third finger of her right hand. She complained of throbbing hand and arm pain but was otherwise in no acute distress. Vital signs were: T, 37.2°C; P, 100; R, 24; and BP 170/70.

Her physical exam was within normal limits except for her right extremity. Two small puncture wounds were present 1 cm apart proximal to the PIP joint of the third finger and were oozing serous material. The third finger and right wrist were swollen and markedly er-

(Continued next page)

ythematous. The third finger was ecchymotic at the bite site. Some erythema was streaking up the right arm.

After a negative intradermal test (0.1 ml 1:10 dilution) five vials of Wyeth Crotalidae Polyvalent Antivenin in 0.9% NaCl were infused over 20 minutes. She was treated with DT 0.5 ml IM and Ceftriaxone 1 gm q 24 hours IV. Initial laboratory analysis revealed 23,000 platelets and fibrinogen degradation products (FDP) greater than 80 but normal hematocrit (35), hemoglobin (12), prothrombin time (11), partial prothrombin time (30) and fibrinogen (345).

Also within normal limits were serum electrolytes, blood urea nitrogen, creatinine, total protein, uric acid, albumin, alkaline phosphatase and total bilirubin (0.6). Tissue enzymes appeared normal with LDH 128 and SGOT 15.

The hand and arm pain and swelling continued until the third hour post bite when five more vials of antivenin were infused. The patient reported a decrease in pain after the seventh vial and swelling of the hand, wrist and forearm stabilized. A blood check during the fifth hour post bite showed a tripling of the platelet count but no improvement in FDPs. Both the pain and swelling resumed during the eighth hour post bite and four more vials of antivenin were infused. This was followed again by a decrease in pain and stabilization of swelling of the hand and wrist but a continued swelling of the upper arm.

Swelling of the axillary region of the upper arm began and another four vials of antivenin were infused 29 hours post bite. This was again followed by decreased pain and swelling except for the upper arm. By the next day, 51 hours post bite, all swelling was resolving. FDPs did not begin to decline until the third antivenin treatment and did not approach normal until 75 hours post bite.

Interview of the patient one year later revealed that she had suffered some joint pain and did not "feel normal" for about six months. It is likely that this was due to mild serum sickness rather than effects of the venom.

Fatal bites are rare

Fatal bites from massasaugas are rare.[5] A fatal bite from this species involving a 41-year-old previously healthy female has been reported.[6] In this case, suction was applied to the wound but no antivenin was used. The bite developed much like the fourth case reported here except that at the time of death ecchymosis had spread beyond the bitten limb. The patient was reported as in pain but cheerful and in no apparent distress until the sixth day post bite; she died suddenly on the seventh day after complaining of chest pain and difficulty breathing.

Autopsy revealed the bitten arm to be badly swollen although the bitten hand was grossly normal. "A complete failure of post mortem coagulation of blood" with hemorrhages in various tissues also noted. The muscles in the bitten forearm were virtually destroyed and the walls of many venules had disintegrated.

Minton and Minton analyzed lethal dosages and toxicity of snake venoms and found that massasaugas have a highly toxic venom, more potent than that of timber rattlesnakes.[7] Massasaugas typically inject relatively small amounts but are capable of injecting more than one lethal dose.

Physicians should be alert to venomous snake bite in Iowa and should consider massasauga bites to be potentially dangerous. The greatest threat appears to be from loss of platelets partly resulting from disseminated intravascular coagulation.[8] Destruction of small vessels and muscle may result from prolonged exposure to the venom. However, treated massasauga bites, unlike bites of many other crotalid snakes, rarely produce significant local tissue necrosis.

Treatment of massasauga bites

Because of potential adverse serum reaction it is desirable not to treat nonvenomous bites with antivenin. In addition, it is estimated that up to 40% of venomous snake bites do not involve significant injection of venom.[5,7] Severe pain and swelling within the first few minutes of the bite provide evidence of envenomation by massasaugas. Although nonvenomous snake bites commonly leave several tooth marks, only rarely do venomous crotalid snakes reach the skin with their smaller teeth. One or two fang marks should be visible and these usually weep fluid.

Suction is probably of value in removing some venom from the wounds during the first two hours post bite but enlargement of the wounds has been questioned (Minton Pers. Comm.).[5] A skin test for serum sensitivity must

be given prior to antivenin treatment. Polyvalent crotalid antivenin is effective against the venoms of all of Iowa's venomous snakes and is most effective when infused.[5]

Treatment with antibiotics is essential to control bacterial infection. Because of lack of necrosis from treated massasauga bites, fasciotomy is never necessary if antivenin is used within the first 24 hours. Transfusion of blood products is generally unnecessary if antivenin can be used. It may be necessary if antivenin is unavailable or if the patient reacts to horse serum.[8]

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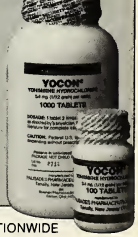
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AMA renews call for physician input on health care reform

During the crucial first 100 days of the Clinton Administration, the American Medical Association stepped up its involvement in the health system reform debate. AMA's goal: to ensure that patients' needs remain the focus of system reform.

The AMA organized an unprecedented two-day Washington summit, "A Time for New Partnership," on March 23-25 to encourage dialog between physicians and the Clinton Administration and Congress. Physicians from across the country gathered in Washington to hear Vice President Al Gore speak on health system reform; HHS Secretary Donna Shalala and Majority Leader George J. Mitchell (D, Maine) also addressed the physicians.

After a briefing by AMA legislative staff, the physicians visited with their representatives in Congress.

The AMA is continually working to make the voice of American physicians heard in Washington. As AMA EVP James S. Todd, MD, stated in a letter to White House senior health policy adviser Ira Magaziner, "Bring us into the process, and we can help make it work. Without the 'buy-in' of people in the front lines of health care delivery, enactment and implementation of reform will be much more difficult."

Contest boosts AMA's anti-tobacco crusade

AMA and U.S. Surgeon General Antonia Novello, MD, are sponsoring a nationwide contest to increase children's awareness of the dangers of smoking. AMA President John L. Clowe, MD, said the contest is part of the AMA's and the surgeon general's continued campaign to achieve a smokefree environment by the year 2000.

The contest is designed to combat the tobacco industry's "spending millions of dollars in advertising to encourage young children to start smoking."

AMA and the surgeon general last year sponsored a protest march in Chicago against cigarette advertising that targets children. They also demanded that R.J. Reynolds Co. drop ads featuring the company's most effective marketing tool — the cigarette-smoking Old Joe Camel that appeals to children.

The nationwide contest, called "Say No, Old Joe," is aimed at the Camel cartoon. Studies published in the December 10, 1991 JAMA showed children six years of age and older found the character just as recognizable as the Disney Channel's Mickey Mouse logo. Old Joe Camel's appeal increased smoking of that brand among children from five percent to 32 percent during a three-year period, the studies found.

"The AMA will continue its fight to eliminate underage smoking and put pressure on cigarette manufacturers who use deplorable advertising tactics to entice children to begin smoking," said Lonnie R. Bristow, MD, AMA vice chair. "Maybe Old Joe Camel has taken his last puff?"

Prepared by the Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

Smokefree workplace rules supported

The AMA urged Secretary of Labor Robert Reich to develop and promulgate standards that provide a smokefree work environment for all employees as soon as possible.

A letter from AMA EVP James S. Todd, MD, states the Association's belief that "this could be accomplished most easily by a total ban on smoking in the workplace." However, the letter said a standard might allow — but not mandate — a fully enclosed, separately ventilated designated smoking area for employees.

Citing an Environmental Protection Agency report released in January on the health hazards imposed by "passive" smoking on nonsmokers, the AMA said it now "is evident that action is needed on behalf of America's labor force." The letter urges that the Occupational Safety and Health Administration separate environmental smoke from other problems of clean indoor air.

AMA testifies before CLIA committee

Physicians must be allowed to perform certain laboratory tests in their offices without undue restrictions, to meet patient care needs and to help contain laboratory costs. J. Edward Hill, MD, of the AMA's Council on Legislation, recently delivered this message to the Clinical Laboratory Improvement Advisory Committee in Atlanta.

Dr. Hill addressed issues related to the physician-performed microscopy category. He stressed that HCFA, CDC, and the committee must share in complying with CLIA, including technical and administrative complications and assuring patient access to medically necessary laboratory services.

He said physicians are overwhelmed by CLIA, OSHA and ADA regulations, which are costly and time-consuming to administer. Many physicians are deciding not to perform laboratory tests in their offices as a result, Dr. Hill added.

AMA applauds new AHCPR guidelines

The AMA commended the Agency of Health Care and Policy Research for introducing its newest clinical practice guidelines on cataract surgery. The new guidelines suggest physicians should postpone surgery and use other measures to improve visual functioning until the cataract becomes too problematic.

"In an era when, more than ever, every medical dollar counts, the continuing development of practice parameters means that medicine and government are prepared to meet the challenges of the era by improving patient care while effectively managing costs," stated AMA EVP James S. Todd, MD. "Working with AHCPR has given us the opportunity to forge a new partnership between medicine and government with the potential to vastly improve patient care."

The AMA, working with other physician organizations, is leading activities to ensure the medical profession maintains control over the development and application of practice parameters that improve patient care and effectively manage costs.

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Your medical practice should have policies in effect to protect your interests and to protect those who work for you.

Policy recommendations

Physician involvement is vital. It is recommended that the physician sign all of the checks. If this is not possible, the manager should attach the signed checks to the documentation for the physician's review. Complete documentation should accompany each check. Never sign a stack of checks without invoices or documentation. This will help you keep a handle on expenses.

Any refund checks to patients should be accompanied by a copy of the account ledger showing the patient's name, address and balance information.

All write-offs or courtesies to employees and their families should be reviewed and initialed by the physician. This protects you and the person responsible for doing the adjustments to the accounts.

Any reimbursement to an employee for purchasing of supplies should always be accompanied by a receipt.

This article was written by John Leavell, a member of the Iowa Medical Group Management Association.

It is a good idea for someone other than the cashier to do the daily deposit. All monies received through the mail or over the counter should be balanced and then given to the manager or employee who prepares the bank deposit. It will serve as a second balancing tool and as a safeguard to the employees and the manager if more than one person is responsible for money handling.

'Your medical practice should have policies in effect to protect your interests and to protect those who work for you.'

If you keep a petty cash fund that is used frequently, review it periodically or have your accountant or auditor review it. Make sure there are receipts for all transactions.

Review your financial reports monthly. If something seems out of line, question it. Have an audit done at least yearly and more often if possible.

Communication

If you have taken the time to put policies into effect, be sure to follow up. As the physician owner of your medical practice, you'll want to communicate with your manager, accountant and auditor regarding financial matters. Ask questions and observe. It's your money . . . know where it's going.

Be a critical reader

Richard M. Caplan, M.D.

FOR A LONG TIME, at least throughout this century in the United States, reading has clearly won any survey that asked how physicians gain their continuing education, and how they wish to gain it. Even our American eagerness for technical progress in the form of satellite broadcasts, audio and video recordings and instructional computers has not usurped the lead enjoyed by reading—mainly journals. Accurate communication via the written word remains exceedingly important.

Poets, novelists and dramatists may strive for uncertainty or ambiguity, specifically to allow for the richness of interpretation that characterizes great art. Thus, metaphors and *doubles entendres* abound. But good scientific writing, even though it cannot totally avoid similes and metaphors as a necessary component of thinking, still seeks as much exactness of meaning as possible: writers must make themselves understood, but must also eliminate or reduce the possibility of being misunderstood. Accurate communication, however, requires effort by the receiver (reader) as well as the sender (writer), an effort that needs lots of practice and reinforcement. Thus, I've long thought that drills in proofreading would yield valuable payoff. Can one learn or improve skills at being sharp-eyed and sharp-eared? I think yes.

One method of value is to study writing closely enough that the mind attends fully. One must do what Sherlock Holmes or any other good clinician does—examine with closeness, seeking to notice both trees and forest (a metaphor that's useful, but also a cliché now from overuse). That's partly what justifies having journal clubs—to read an article carefully enough to join a discussion about it. Book clubs provide similar training. Formal coursework in literature, history or philosophy offer good practice at learning to read and write with the sort of diligent care that I'm describing.

Being a careful reader, mentally interacting with the text that faces you (not necessarily a textbook), means you might be stopped cold when you read this sentence: "Late experiments by Roentgen . . . prove that lead is transparent to these [X-] rays." Something is drastically wrong with that information, since we use lead as our major shield, yet I quote it directly from a photocopy of the *Des Moines Leader* of February 23, 1896, which in turn cited information from the *London Standard*. I doubt the error was Roentgen's, although it was only about two months earlier that he made his first startling presentation about the rays that now bear his name. The reproduced page I mention is part of an exhibit in the new medical museum on the 8th floor of University Hospitals in Iowa City. This splendid show, open throughout 1993, presents the history of imaging. Among the many artifacts is a never-unwrapped Egyptian mummy with its bodily details disclosed by "conventional" radiographs, CT scans and MR imaging. You needn't be a radiologist to enjoy this exhibit.

All this relates to my cautions about being a careful reader. In other words, don't believe everything you find in print, with the possible exception of the funny-papers, where startling truths and insights abound these days.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

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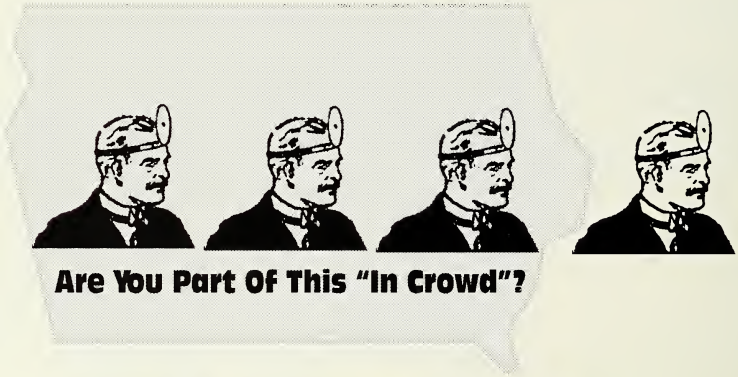
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John Anderson, M.D.

Let's control our destiny

THIS IS TRULY A HIGH POINT in my career. I am honored to be entrusted with the office of IMS president and I promise I will do my best to represent the physicians of Iowa. I tip my hat to my predecessor, Bill Eversmann, who set high standards for this office during the past year. Bill has been a tireless spokesman for Iowa physicians and we all owe him our gratitude.

The coming year could be a significant one for Iowa physicians and physicians across the country. It's probably not going to be an easy year for any of us. Most physicians have known for a long time that our health care delivery system is in trouble and it appears that reform is now just around the corner. What we don't know is what form it will take or, indeed how a concensus of opinion will be found. Mrs. Clinton's task force continues its deliberations and, right here in Iowa, the Governor's Council on Health Care Reform has begun its momentous task.

The end result of all this attention to health care reform could be chaotic. One thing is certain—doctors will be facing many hard decisions. When we are making these decisions, I only hope we can keep one consideration firmly in our minds . . . what is best for our patients. In the coming months, this may be easier said than done, but we may be the only true advocates our patients have in the midst of a myriad of other issues. We cannot allow cost considerations to dictate what is best for our patients. We cannot allow ourselves to be cast in the role of "Health Care Rationers" trying to operate within global budgets set by people who know nothing of day-to-day patient care.

Obviously, we must stay informed about health care reform. Yes, you're a physician and taking care of people is your main focus. But, I believe we all have an obligation to keep up with health care reform proposals because it will ultimately have the most effect on our patients. Read newspapers and magazine articles on health care reform. Watch the evening news. Make sure you know what's going on because it's unthinkable to keep your head buried in the sand.

You must also be involved. I'm going to need every one of my colleagues in our effort to shape the best health care delivery system possible. We'll also be relying on our spouses and families to join our team.

The final thing we'll need on the road to health care reform is unity. Yes, physicians have been taught to be independent thinkers, but we cannot appear to be a house divided on the issue of health care reform. Organized medicine at all levels must be a united advocate for quality patient care and must communicate that position effectively to the public and the government.

You'll be hearing more from me on this subject during the coming year.



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Marion E. Alberts, M.D.

Act like an animal

Often, when someone is acting in an antisocial manner, they are said to be "acting like an animal." Young lads are advised to "grow up like a man." I contend that these are misused analogies because humans are among the crudest and most antisocial animals on earth. Let me draw a word picture of my concept of the behavior of humans versus that of lower living beings.

First let us examine the issue of self-destruction, i.e., the lack of self preservation of well-being. Statistics adequately demonstrate that many humans harm their bodies and emotional well-being through the use of alcohol, drugs and tobacco. Some people invite reckless life behavior and self-destruction through unwise actions and risk-taking. In addition, poor diet and exercise habits have detrimental effects upon the body.

When chastised about poor lifestyles a stock answer often is "Don't dictate to me how I live or enjoy life."

How many lower animals are so blatantly self-destructive?

Next, let us examine the relationships of humans one to another. Wanton behavior in the form of assault or murder—often in defiance of reason—is another human trait. Lesser animals kill other species for sustenance much in the way we slaughter cattle, pigs or chickens for food. But, lesser animals rarely kill or maim their own kind. Furthermore, throughout history humans have been at war in some areas of the world. The atrocities occurring in certain areas of the world are beyond the behavior exhibited by lesser species. Ironically, many wars are based on religious or cultural ideologies. Why do humans hate other humans so much? Territorial acquisition often is the basis of conflict—large scale turf wars as it were.

Humans pride themselves on being the acme of intelligence. Yet, that intelligence is misdirected to invention of destructive tools, each tool being more complicated and more destructive than the preceding one.

It is easy to perceive that more and more humans are victims of stress which upsets their emotional equilibrium. Tranquilizers or mood-altering drugs are most often prescribed. Have you ever heard of baboons and hyenas requiring tranquilizers? Their tribal type of life takes care of their problems because they live together in a more sane manner than humans.

Our society is becoming more corrupt and unruly. Confrontations, riots, crime and wars are rampant. Crimes of violence have crippled many sections of our cities. Medical facilities are overburdened caring for persons who defy nature by using harmful substances or ignoring preventive health measures. It is time to take a hard look at ourselves, and perhaps begin by "acting like animals."

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Stowaway

DR. STAN HAUGLAND IS A PLAYER in a true-life drama worthy of that old television classic "This Is Your Life."

In 1946, Dr. Haugland—now a Des Moines family physician—was a merchant seaman aboard the SS John Miller when his ship docked for several weeks in the port city of Piraeus, Greece and some very interesting events unfolded.

"Everything was very bad in Greece and I remember young children eating paper on the streets. There was political turmoil and gunfire in Constitution Square in Athens," Dr. Haugland recalls. "I became acquainted with a Greek family who had a young man—a freedom fighter—trying to leave Greece and come to America. I was 18 at the time and full of adventure."

Sailor turned smuggler

Being full of adventure and "not aware of the full implications of such an act," Dr. Haugland agreed to smuggle the young man on board his ship. The young man had an uncle who operated a dairy in Portland, Oregon. The uncle was sent a telegram advising him to meet his nephew when the American ship docked in Baltimore.

The knottiest problem lay ahead—how to get the young Greek aboard the ship.

"I cut his hair, got him some khakis to wear and got him drunk," Dr. Haugland relates, smiling. "We put our arms around each other and staggered onto the ship like two sailors who had been out on the town. Then I locked him in the hold of the ship with a few rations."

Of course, plans rarely come off without some kind of a hitch.

"About three or four days out to sea, they searched the ship and discovered my stowaway. They put him to work on the deck or wherever the captain of the ship wanted him, but he never told anyone how he got there. In fact, his uncle met him at the dock in Baltimore and no one ever discovered I was instrumental in helping him travel to America," Dr. Haugland says.

Fast forward

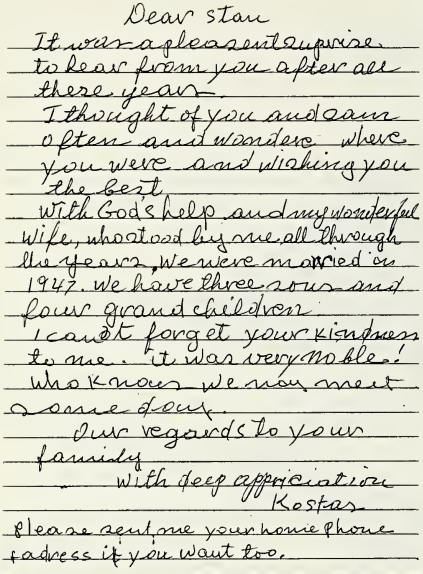
Now, the story jumps ahead to nearly 46 years later when a Greek physician named Jim Speros moved from Portland, Oregon to Des Moines. Dr. Haugland asked Dr. Speros how he might locate his stowaway friend, who may or may not have settled in Portland and whose name he did not remember. Dr. Speros put Dr. Haugland in contact with a colleague in Portland, and Dr. Haugland describes the end result:

"You can't imagine what it is like to trace someone down in America. I called him on a Sunday morning and asked if he was Kostas Lilles, and he said yes. I said 'This is Stan' and he asked 'Stan who?' 'The Stan who smuggled you on board ship 46 years

(Continued next page)



Dr. Haugland (left) and Kostas Lilles reunited.



May 5th 1992

Dear Stan

It was a pleasant suprise to hear from you after all these years. I thought of you and am often and wonders where you were and wishing you the best. With God's help and my wonderful wife, who stood by me all through the years. We were married in 1947. We have three sons and four grandchildren. I can't forget your kindness to me. It was very noble. Who knows we may meet some day.

Our regards to your family

With deep appreciation

Kostas.

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ago in Greece.' There was the longest pause and then he started to cry. So did I."

During the ensuing telephone conversation, Dr. Haugland learned that Kostas was held for nearly five months in Ellis Island when he first arrived in America. He was harrassed by officials of the Greek government and questioned by Greek and American officials about who had helped him get into the country.

"He never told. His father had told him never to reveal who helped him, on pain of death," Dr. Haugland reveals. "Kostas says

'I became acquainted with a Greek family who had a young man—a freedom fighter—trying to leave Greece and come to America. I was 18 and full of adventure.'

he spent lots of money and time trying to become an American citizen."

Kostas became a citizen, got a job driving a truck and eventually opened his own restaurant. He lives in Lincoln City, Oregon, has been married since 1947 and has three sons and five grandchildren.

Emotional reunion

Finally, our story jumps to March of 1993, when Dr. Haugland and his wife traveled to Oregon for a reunion and visit with Kostas and his family. Dr. Haugland says he spent a delightful three days with the man he helped escape from a country in turmoil so long ago. But, the story doesn't end here. The Haughlands and the Lilles are now planning a trip to Greece "to retrace our steps." This trip should be especially meaningful for Kostas, who has not returned to his homeland.

"It's been so interesting to reestablish contact with Kostas to find out that he is still very glad he came to live in America," Dr. Haugland concludes. "I suppose that's much of the reason I was so willing to assist him. My own father and mother struggled mightily to get to America from Norway when they were young and I guess that made me sympathetic to his cause."

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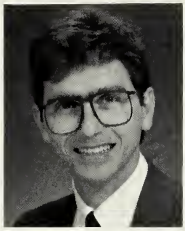
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David Lyons

Changing the landscape of Iowa's health care system

The author, Iowa insurance commissioner and newly appointed chairman of the Governor's Health Care Reform Council, discusses the group's plan for a major reform of Iowa's health care delivery system.

You have been appointed by Governor Branstad to chair the Iowa Health Reform Council. Who is on the Council and what are the group's goals?

The Council has more than 50 members from the private and public sectors across the state. It is comprised of individuals who can provide vision for greater value in health care and greater fairness in financing and access.

Past experience teaches us the legislature must be involved in crafting reforms. Legislators on the Council were selected by the leadership of each caucus, assuring bipartisan participation. Key state agency heads represent the executive branch. Physicians and hospital administrators are on the Council, as are insurers.

If you are asking people to change, you must involve them in finding solutions. Individual consumers and businesses, large and small, are also members.

The more difficult question may be who isn't on the Council. With so many interested and qualified candidates, many groups—like physician specialties—are not directly represented at the Council level. However, the 16 subcommittees, where much of the written work product will be done, will offer another important layer of involvement. We are also planning focus group meetings with particular constituencies as plans progress and public outreach meetings featuring education and comments.

Governor Branstad expects the Council to continue Iowa's tradition of cooperative, consensus-based health care reform. Some people allege that consensus-based reform leads to the "lowest-common denominator," but I have to disagree. If you ask Iowans to

share responsibility for solutions, they tend to respond with vision and dedication beyond their immediate parochial interests.

The Council will develop a comprehensive health care reform proposal and will seek to influence national health care reform policy to accommodate Iowa's needs. We want to avoid being a victim of federal reform.

The Council will recommend specific implementing legislation before the 1994 session of the General Assembly.

What process will the Council follow in crafting a health care reform plan?

Our goal is an open, honest and focused debate. We think this is best accomplished by establishing a common understanding of the systemic problems, and a shared statement of principles.

Against this background, alternative solutions can then be tested for whether the solutions address the primary problems and whether the solutions adhere to Iowans' shared principles.

I contrast Iowa's open process with the secretive process in Washington. I think the Clintons are missing a golden opportunity for educating consumers, taxpayers, patients and voters about the problems of our health care delivery and financing system. Reform is not just for the uninsured. It can and must benefit the insured, the buyer and the provider communities. A closed process denies opportunities for creative minds to contribute and share in the solutions.

What role will Iowa physicians play?

Several physicians are members of the Council. Many more will be involved on subcommittees. Beyond that, all physicians will necessarily play a key role in any reform. Physicians and other medical professionals are the point of the spear. Successful reform will require the active support of the medical community. We cannot improve the value of health care without having physicians involved in the solutions.

How does the work of the Iowa Leadership Consortium fit into the work of the Health Reform Council?

The Council is a direct descendent of the ILC. The Robert Wood Johnson Foundation Grant received by the state was based upon work of the ILC. Since that time, the project has moved beyond research to an active public effort to forge political consensus for comprehensive reform.

We would not be as far as we are today without the seminal work of the ILC. The ILC's work product is one of the base documents that the Council will consider, but the Council's eventual proposal may or may not resemble the ILC's. I believe some features will carry through, such as a more universal system and a preference for a minimal role for government.

Will health care reform at the federal level preempt efforts to reform Iowa's system?

If anything, the opposite is true. All indications are that federal reform will be only a framework and states will be asked to fill in the details. Iowa has a significant interest in influencing the framework to accommodate our preferred model and in being ready to act whenever the federal framework is set. I cannot see financing increased access out of sync with other states due to the adverse effect on economic competitiveness.

I can see the benefits of leaping ahead as soon as that federal framework is in place. The status quo is too costly. Iowa can turn health care reform into a competitive advantage. I am convinced with the quality of our medical providers and the talent of our business and insurance community, Iowa will find a better way to deliver cost-effective, high quality health care to all of our citizens.

Editor's Note

The following IMS members are serving on the Iowa Health Reform Council: **William Eversmann, Jr., M.D.**, Cedar Rapids; **Jolynn Glanzer, M.D.**, Cedar Rapids; **Steve Gleason, D.O.**, Des Moines; **Charles Helms, M.D.**, Iowa City; **Gerald McGowan, M.D.**, Sioux City; **Deborah Turner, M.D.**, Bettendorf; **Steve Vanourney, M.D.**, Cedar Rapids. Approximately 50 physicians are serving on IHRC subcommittees and two IMS staff members are providing support services.

Increasing breastfeeding rates is task force goal

Note: This material was provided by the Iowa Department of Public Health.

SINCE 1982, THERE HAS BEEN a continuous decline nationally in the number of women who breastfeed and in the length of time women breastfeed. By 1989, rates had fallen to 52.2% for women who breastfeed and to 19.6% for those still breastfeeding at six months.

Iowa data on breastfeeding does not compare favorably with national data. In 1991, the incidence of breastfeeding initiation in Iowa was 49%, according to the Iowa Newborn Metabolic Screening program. Duration of breastfeeding in Iowa at six months was 17.5% in 1991 based on preliminary information from the Ross Laboratories Mothers' Survey.

Iowa Lactation Task Force

Because of interest and concern about breastfeeding in the state, the Iowa Department of Public Health acted as a lead agency in the formation of the Iowa Lactation Task Force in 1986. The task force includes representatives of various medical specialty organizations and state agencies. The group's purpose was to increase the proportion of women breastfeeding their babies at hospital discharge to 75% and to 35% at six months of age.

This goal was revised by the federal government in its *Healthy People 2000: National Health Promotion and Disease Prevention Objectives.* The year 2000 national objective strives to "Increase to at least 75% the proportion of mothers who breastfeed their babies in the early postpartum period and to at least 50% the proportion of mothers who continue breastfeeding until their babies are five to six months old."

The task force issued a position statement encouraging breastfeeding because breast milk provides an ideal balance of nutrients for the human infant, breast milk contains immune factors and anti-infective properties, breastfed infants have fewer allergies and breastfeeding promotes bonding between mother and infant.

The task force is striving to meet the national year 2000 objectives for breastfeeding prevalence and duration and supports the following strategies:

- Inform expectant parents of the advantages of breastfeeding
- Provide expectant mothers with information on how to prepare for, initiate and maintain lactation
- Encourage practices that support breastfeeding in all sectors in the health care system
- Institute policies in worksites that create an environment fostering success in breastfeeding
- Increase public awareness of the benefits of breastfeeding
- Increase community services that support breastfeeding.

The Iowa Lactation Task Force conducted a hospital survey in 1992 to collect information about present hospital breastfeeding practices, identify breastfeeding specialists in the state and monitor trends. Correlations will be made between the results of this survey and an earlier hospital survey.

Present activities of the Iowa Lactation Task Force include conducting a mothers' survey to provide data on demographic characteristics, prepregnancy infant feeding decisions, hospital practices, problems related to breastfeeding, problems related to support systems for the mother, factors related to the discontinuation of breastfeeding and the breastfeeding support women receive when returning to work.

Statewide workshops

The Iowa Lactation Task Force is also providing breastfeeding support workshops across the state with emphasis on community support services for breastfeeding. Four workshops were conducted in Iowa during fiscal year 1992 and six more will be conducted in fiscal year 1993. As a result of the workshops conducted so far, four communities have formed local task forces to address breastfeeding promotion and support issues in their communities and several others are in the initial stages of task force formation.

Membership in the task force is open to all organizations and individuals. Contact Carrie Peitzmeier, nutrition consultant, Iowa Department of Public Health, 515/281-7501.

Frostbite textbook

Dear Editor:

Dr. William J. Mills, Jr., Anchorage orthopedic surgeon, is a world renowned scholar of themal injuries. He has spent some of his retirement hours summarizing the literature of that field. In the 1970s, Dr. Mills and his associates wrote several papers that were published in *Alaska Medicine*. At that time *Alaska Medicine* was not listed in Index Medicus.

Alaska Medicine, now indexed, will devote Volume 35, No. 1 to cold injury. The earlier articles will be republished along with his summation of the subject.

I would ask that you publish this letter to alert your readers to what we hope will prove to be a mini textbook on frostbite. Your readers may order a copy from our Anchorage office for $10 plus $2.50 shipping and handling. Address: *Alaska Medicine*, 4107 Laurel Street, Anchorage, Alaska 99508.— *Donald Rogers, M.D., Anchorage, Alaska*

Anaphylaxis death

Dear Editor:

I would like any report of deaths or near deaths from anaphylaxis due to food or insect allergy. I would also like reports of deaths that were prevented by the use of epinephrine kits. Information may be sent to Claude A. Frazier, M.D., 4C Doctors Park, Asheville, N.C. 28801.

Your colleagues want to hear from you!

It's important for Iowa physicians to share opinions about current health care issues. If you have a comment regarding something you've read in IOWA MEDICINE or an issue affecting the practice of medicine in Iowa, don't keep it to yourself. It's very easy to share your thoughts in a letter to the editor.



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Ron Richmond, MD, joined the CompHealth locum tenens medical staff when he completed his residency. He wanted to travel. He loves to meet people. A little time off sounded really good. And he thinks being exposed to different types of medical practice will serve him well when he returns to his hometown to establish a community health center.

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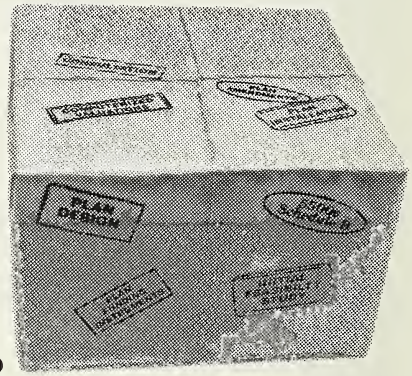
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Sun induced dermatoses

Despite repeated public information campaigns, acute sunburn continues to be a common problem. But, it's not only the skin complaint caused by the sun during the summer months, says an Iowa dermatologist.

Shawn Sabin, M.D.
Dubuque, Iowa

With the arrival of warmer weather in the Midwest, participation in outdoor activities increases. Although emphasis is placed on the more chronic problems with ultraviolet A (UVA) and ultraviolet B (UVB) exposure, namely skin cancer and photoaging, patients may also experience skin eruptions acutely associated with sun exposure. This article reviews the common acute sun-induced dermatoses and their treatment.

Sunburn persists

Despite warnings, acute sunburn is a common problem, especially early in the warmer season. In addition to the clinically apparent erythema, sunburn damages DNA and cell membranes and causes the release of cytokines and mediators of inflammation. UVB radiation (290-320nm) causes most of the acute erythema of sunburn.

The clinical presentation is mild to bright erythema and edema of sun-exposed areas of skin, with tenderness and occasional vesicle formation. Signs of erythema begin two to six hours after exposure with intensity of erythema at its maximum 15-24 hours later. In intense reactions, sloughing of the skin will occur over the next 48 hours. With less intense exposure, peeling occurs later. Reactions usually fade over a few days.

Treatment of sunburn should include cool wet compresses, topical corticosteroids and emollients. Systemic acetylsalicylic acid is suggested to decrease the inflammatory prostaglandin effect. Patients with severe sunburn may need monitoring for fluid replacement and infection. In counselling patients, prevention of sunburn should be the goal. Sunscreens of SPF 15 or greater should be used and reapplied every few hours.

Photosensitive drug reactions

Reactions to drugs induced by ultraviolet radiation can be phototoxic, or non-immunologic. These reactions resemble a sunburn and can occur with the patient's first exposure to sufficient doses of the photosensitizing chemical and the appropriate wavelength of radiation.

Photoallergic drug reactions, however, involve the immune system in addition to the

Dr. Sabin is in the private practice of dermatology in Dubuque.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR JUNE 1993

photosensitizing chemical and radiation. Rather than a severe sunburn, these reactions may present as eczematous changes or as a papular or plaque-like eruption. A delayed hypersensitivity immune response is seen, so eruptions are not seen on first exposure.

Drugs most commonly causing photosensitive drug eruptions include phenothiazines, thiazides, griseofulvin, sulfonamides, nonsteroidal anti-inflammatory agents (benoxaprofen, piroxicam), tetracycline, DTIC, chloraquine, vinblastine, methotrexate, sulfonylureas, fluorouracil, furosemide, amiodarone and psoralens. Topical preparations can cause both phototoxic and photoallergic reactions.

Agents causing phototoxic type responses include coal-tar derivatives, dyes and furocoumarins in plants such as the Umbilliferae group including limes, celery, figs, and parsley. Photoallergic responses are caused by some topical antifungals, fragrances such as musk ambrette, halogenated salicylanilides (formerly used as antiseptics in deodorant soaps and cosmetics), phenothiazines, sulfonamides and sunscreen agents including para-aminobenzoic acid (PABA) esters.

Treatment should include elimination of exposure to the photosensitizing agent, minimizing exposure to sunlight for two weeks and topical treatment with cortocosteroids. Systemic antihistamines may be necessary to control pruritis.

Polymorphous light eruption (PMLE)

This is the most common idiopathic photodermatitis in Europe and the United States. It is estimated that 10% of the population has a history of an eruption consistent with PMLE. PMLE is most commonly seen in the spring and summer. Tolerance usually develops with continued sun exposure, a characteristic known as "hardening." The majority of patients develop a pruritic, burning, tingling, erythematous eruption on exposed skin. Papules, plaques or papulovesicular lesions may occur. Areas of normal skin seen between the papules is common and can be a clue in the diagnosis. The lesions may persist one week or more.

Treatment should include minimizing exposure to sunlight with UVA and UVB blocking sunscreens and clothing. If sunlight cannot be avoided, a gradual increase in sunlight exposure will provide the "hardening" effect. Potent fluorinated topical corticosteroids are helpful for relieving symptoms over a period of days. In more severe cases, systemic anti-malarial agents including chloroquine or hydroxychloroquine may be used. Psoralen and UVA (PUVA) and UVB radiation are sometimes for prophylactic treatment to develop tolerance.

Lupus erythematosus

Approximately 20-30% of patients with systemic lupus erythematosus (LE) will have malar erythema consistent with a "butterfly rash" or a more extensive morbilliform eruption. These are frequently exacerbated with sun exposure. One subset of LE is subacute cutaneous lupus erythematosus (SCLE). Typically, these patients are quite photosensitive. Young to middle aged females comprises 10-15% of all LE patients.

Non-scarring erythematous papules, papulosquamous lesions which are psoriasiform and annular lesions forming polycylic lesions may be seen. Anti-Nuclear Antibody (ANA) is elevated in 70-80% of patients and Ro/ssA antibody positivity is common. Anti-malarials, topical and systemic corticosteroids and sunprotection can all help alleviate symptoms. Sun protection including a UVA blocking agent such as Parsol 1789 is necessary.

Porphyria cutanea tarda (PCT)

PCT is the most common of all the porphyrias, a group of disorders which consist of derangements of steps in the enzymatic steps in the heme synthesis pathway. It consists of a deficiency of uroporphyrinogen decarboxylase and may be hereditary or acquired. The acquired form is usually related to alcohol and estrogen intake. Cutaneous lesions consist of vesicles and bullae seen most frequently over the dorsal hands. A marked fragility of the skin can be present along with hyperpigmentation, hypertrichosis of the face and milia. Skin findings are due to photoactivation of porphyrins in the skin. Urine shows elevated levels of uroporphyrins.

Treatment includes removing the inducing agent in the acquired form as well as photoprotection. Phlebotomy is the treatment of choice with the mechanism of action unclear, possibly decreasing normochromnic erythrocytosis. Also, iron inhibits uroporphyrin decarboxylase and phlebotomy decreases iron stores. Low dose chloroquine has also been used with good results.

Pseudoporphyria is a phototoxic reaction in which the cutaneous lesions mimic those of PCT. A number of medications including tetracycline and furosemide, as well as tanning beds have been reported as causes. Discontinuing the contributing agent and avoiding sunlight are adequate treatment.

Solar urticaria

This is a rare form of urticaria which occurs immediately after exposure to sunlight. It consists of an itching burning sensation with exposed skin becoming erythematous and a wheal and flare reaction which persists up to one hour. Repeated exposure to light results in diminishing cutaneous response. The majority of patients react to the 290-480nm range of ultraviolet light. Some patients show a serum factor which transfers sensitivity, suggesting an immune response. The cause is unknown in those patients without evidence of immune mechanism. Anti-histamines may be used to control symptoms. Tolerance can be induced in patients with increased exposure to sunlight and a maintenance exposure every two to three days.

In addition to being a contributing factor to dermatoses and other acute skin diseases, sunlight can contribute to development of basal and squamous skin cancers, melanoma, premalignant skin lesions and premature aging. It is our responsibility as physicians to warn patients of the possible hazards of excessive sun exposure. We need to encourage photoprotection through use of UVA and UVB blocking sunscreens beginning in early childhood, protective clothing and hats and avoidance of sun exposure during the most intense hours of sunlight betwen 10 A.M. and 3 P.M. Patients need to be reminded that cloudy days do not prevent ultraviolet exposure. Patient education could mean a healthier and more comfortable summer, as well as healthier skin in later years.

Bibliography

Note: A bibliography list for this article is available from the author or the editors of *IOWA MEDICINE.*

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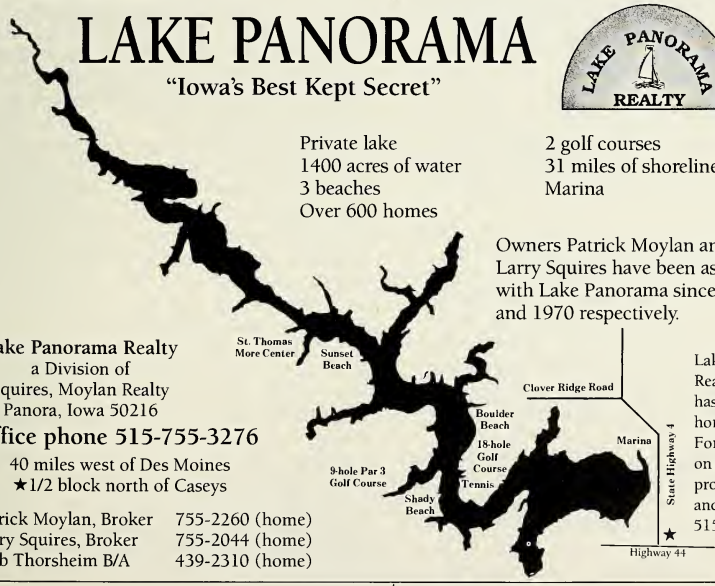
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Weight loss and foot drop

Prolonged or crash dieting should be recognized as a cause of peroneal neuropathy or foot drop. The author presents seven examples in patients.

Erich Streib, M.D.
Cedar Rapids, Iowa

EXCESSIVE WEIGHT LOSS as a contributing factor in peroneal palsy has been reported in starvation, dieting and in patients with serious illnesses.[2,3,6-8] Surprisingly, four major texts on nutrition did not mention this neurological complication of weight reduction. In this age of dieting, the occurrence of peroneal neuropathy in otherwise healthy persons needs to be reemphasized. Its occurrence in severely ill patients is of diagnostic importance.

Case reports

Case 1: A 33-year-old male postal worker came to the emergency room after three days of numbness in his left foot and difficulty walking. Using the Nutri-system, he had lost 14 kgs in eight weeks.

Physical examination revealed left sided dorsiflexor weakness of toes and foot; he was unable to walk on his heel. Sensation was diminished in the peroneal nerve distribution. Clinical signs of polyneuropathy were absent.

Case 2: A 58-year-old woman noticed sudden numbness of the right foot and difficulty walking. She was healthy but admitted to 17 kgs weight loss over three months with a self-imposed diet.

Examination revealed complete right foot drop. Mild dorsiflexor weakness of toes and ankle was present on the left. Both ankle jerks were depressed but sensation was normal.

Dr. Streib is a neurologist with Neurological Associates in Cedar Rapids.

ANA, sed rate, serum B12-level, TSH, glycosylated hemoglobin level and serum protein electrophoresis were normal. EMG revealed bilateral peroneal neuropathy localized to the knee. There was no evidence of polyneuropathy.

Case 3: A 53-year-old woman with DM Type II began an Optifast weight reduction diet. After a 23 kg weight loss in four months, she developed severe burning pain in both feet. Examination showed severe dorsiflexor weakness of both feet and toes, greater on her left. Tendon reflexes and sensation to pinprick and vibratory perception was normal. EMG revealed bilateral peroneal neuropathies localized to the knee level; there was no EMG evidence of polyneuropathy.

Case 4: An 11-year-old sixth grader with anorexia nervosa had lost 4.5 kg within two months. She then developed sudden painless right foot drop. Examination and EMG revealed evidence of neuropathy of the right common peroneal nerve without evidence of polyneuropathy.

She required a foot drop brace. She recovered within two months.

Case 5: A 68-year-old man had been healthy, but overweight. He lost 12 kgs over two months during "self adjustment" of his regular diet. He then noted weakness of the left foot.

Examination revealed moderate weakness of dorsiflexion of toes and ankle and eversion of the left foot. EMG confirmed the clinical diagnosis of common peroneal nerve neuropathy with localization to the knee. There was neither clincial nor EMG evidence of polyneuropathy.

Case 6: An 80-year-old man had multiple medical problems in the preceding year, including alcoholic liver disease, cardiac arrhythmias and hypertension. He lost 22 kgs within four months.

Examination showed neurogenic orthostatic hypotension, mild ataxia, bilateral foot drop and absent vibratory perception in his toes.

EMG revealed evidence of generalized polyneuropathy and bilateral severe peroneal nerve neuropathies with localization to the knee.

Case 7: An 80-year-old woman had bile duct carcinoma and metastatic disease to the lymph nodes and liver. She underwent chemotherapy with 5-FU. This was complicated by severe nausea and weight loss from 142 to 117 lbs within three weeks.

She then noticed numbness of the right foot and progressive difficulty walking. On examination, there was "complete" right foot drop and moderate weakness of toe and ankle extensors on the left. All tendon reflexes were normal and sensation was intact except in the peroneal nerve distribution. EMG confirmed severe bilateral peroneal neuropathies without evidence of polyneuropathy or more proximal neuropathy.

Discussion

Peroneal neuropathy is a common complication of excessive weight loss. The most striking examples were reported in nutritionally deprived prisoners of war. Kaminski described an "outbreak" of foot drop in 35 of 5000 German prisoners of war who lost from 4.5 to 11 kg within two months.[2] Peroneal neuropathy may also occur with self-imposed and controlled dieting of two to four months duration in association with a weight loss of 5 kg per month or more. Sprofkin et al. reported its occurrence in nine patients, Sherman described seven and Sotamieni 10 patients.[6-8] Most patients had asymmetrical, but bilateral involvement.

Habitual leg crossing is known to cause peroneal palsy.[9] Weight loss reduces the amount of fat padding around the peroneal nerve at the fibular head, increasing its vulnerability to compression.[8,9] The compression mechanism is supported by the observations that foot drop occurred predominantly in POWs who were sedentary and the occurrence of peroneal neuropathy in 22 of 181 consecutive depressed inpatients with psychomotor retardation and only moderate weight loss.[2,5] However, other factors play a role.

The patients described by Sotaniemi and our dieting patients did not change their habits or cross their legs more frequently during dieting.[7] The bilateral presentation and the occasional development of more generalized polyneuropathy argue for multiple pathogenic factors.[7] Excessive weight reduction, even when supplemented with vitamins, causes a number of known metabolic abnormalities which affect the peripheral nerves in an unidentified way.[4] Such subclinical neuropathy leads to increased sensitivity to pressure palsies as it occurs in patients with diabetes mellitus or nutritionally deprived alcoholism or in patients with other causes of underlying polyneuropathy.

"Spontaneous" peroneal neuropathy usually presents as a painless foot drop with or without numbness on the dorsum of the foot and anterior lower leg. In an otherwise healthy person, unilateral peroneal neuropathy can be readily identified clinically and distinguished from the principle differential diagnoses of sciatic neuropathy, L5-radiculopathy and lumbosacral plexus neuropathy.

Unilateral foot drop, however, may be the first indication of polyneuropathy and raises a question of a systemic underlying illness.

Bilateral foot drop can mimic polyneuropathy and in a severely ill patient in the ICU, the differential diagnosis includes "critical illness neuropathy" and in the patient with systemic cancer the consideration of paraneoplastic polyneuropathy.[1] In our patient with intra-abdominal cancer, the question of plexus neuropathy or cauda equina syndrome was raised. Electromyography is the most useful tool for neurological localization of peripheral nerve lesions, but it does not determine the underlying etiology of the nerve damage and clincial correlation is needed.

Diet-induced peroneal nerve palsy occurs frequently. It is more common in patients with underlying peripheral nerve disease. Management consists of a balanced diet with more gradual weight loss. A foot drop brace may be needed intermittently. Full recovery of uncomplicated "slimmer's neuropathy" usually occurs within six to 20 weeks.

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For Your Benefit

White House responds to AMA message

Medicine's message is being heard on Capitol Hill as a result of the AMA-sponsored event, "A Time for New Partnership." The event attracted more than 1,000 physicians from every state to Washington, D.C., March 23-25.

In the words of AMA Executive Vice President James S. Todd, MD, "This town hasn't seen anything like what we've done here since the health care debate first heated up nearly two years ago."

Media coverage of the event positioned the AMA as an influential player. News reports were carried in the *New York Times*, *Washington Post* and *USA Today*. Ninety-nine reporters covered the event, which also resulted in coverage on "World News Tonight," "CBS This Morning," and two segments on the PBS "MacNeil/Lehrer News Hour."

Vice President Al Gore spoke to participants, saying the Clinton Administration "knows that we cannot, and do not want to, build a better health care system without the cooperation and leadership of the AMA."

Political heavyweights from both parties spoke, including Senate Majority Leader George Mitchell (D, Maine), Senate Minority Leader Robert Dole (R, Kan.), Sen. Edward Kennedy (D, Mass.), HHS Secretary Donna Shalala and other top leaders.

On day two of the event, the AMA organized groups of physicians to meet with their congressional representatives.

Also while in Washington, AMA's Board of Trustees met with Ira Magaziner for the fourth time. The meeting resulted in a "full and productive exchange of ideas." Magaziner asked for input from the medical profession on system reform. AMA trustees said many elements of the administration's proposal are in sync with the AMA's Health Access America plan.

HCFA extends Medicare claims denial deadline

After intensive efforts by the AMA, the deadline for denial of Medicare claims that lack a CLIA registration number is extended indefinitely by HCFA.

The agency initially published final regulations under which Medicare would have started denying claims for lab tests when there was no CLIA registration on file as of Sept. 1, 1992.

The deadline was originally extended to Dec. 1, 1992. HCFA subsequently decided its internal data processing system required modification and extended the deadline to March 1.

The agency then said an indefinite extension was needed to analyze claims processing requirements.

Prepared by the Department of Communications Services. For information, call 800 AMA-3211, ext. 4416.

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Changes in IFMC Review Activity

IOWA PHYSICIANS AND PROVIDERS will notice fundamental changes in IFMC review activities in the coming months. IFMC review will move away from concentration on individual clinical errors toward helping physicians and hospitals improve the mainstream of care through research projects and quality improvement.

This change will take place through cooperative initiatives and more educational feedback to physician and provider groups. Following are key components of the changes and the types of feedback you can anticipate from the IFMC.

Health Care Quality Improvement Initiative (HCQII)

The fundamental changes in the IFMC's review activities will be anchored in HCQII. Through HCQII, the IFMC will analyze patterns and outcomes of care. The IFMC will share its findings with physicians and hospitals as a means of identifying ways to improve care and outcomes of care. Under HCQII, the IFMC will devote more energy to physician and provider education.

A national cooperative pilot project developed under HCQII is the Cooperative Cardiovascular Project (CCP). The CCP will require the IFMC to collect and analyze UCDSS (Uniform Clinical Data Set System) data on Medicare cases involving acute myocardial infarction (AMI), coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA). The CCP will provide hospital-specific information to each hospital and its medical staff on patterns of cardiovascular care, identify and analyze areas where opportunities for improvement exist and help hospitals develop programs for change.

As a pilot PRO for the CCP, the IFMC will solicit the help of Iowa physicians. The IFMC has recruited Timothy Kresowik, M.D., of the University of Iowa Department of Surgery, to serve as its principal clinical coordinator. Dr. Kresowik will work directly with local hospital and medical staffs on cooperative projects. Physicians in Iowa will have an opportunity to attend informational meetings across the state.

Uniform Clinical Data Set System (UCDSS)

UCDSS, another HCFA-directed project, was designed to increase consistency in the medical review process. UCDSS allows for collection of nearly 2,000 uniformly defined clinical data elements from the medical record on the health of the patient and the diagnostic and treatment activities provided during treatment.

Complex, professionally developed computerized algorithms (decision trees) evaluate these data and determine whether to refer the case for physician review or approve the case. Implementation of the UCDSS is expected to result in major enhancements in data collection efficiency and greater usefulness of collected data.

The IFMC has been involved in the UCDSS pilot program since its implementation in various capacities: data abstraction, software development, algorithm refinement, and communication efforts. Beginning April 1, the IFMC began performing traditional review and UCDSS review simultaneously on a 5% beneficiary-specific sample. This dual review will help the IFMC identify clinical problems with the UCDSS algorithms.

Case review

Over the next six months, case review performed by the IFMC will have decreased by about ⅓ of its present volume to approximately 1,100 reviews per month or a 12% sample of discharges. This 12% will include:

(Continued next page)

This article was written by Rebecca Hemann, IFMC vice president of government review services.

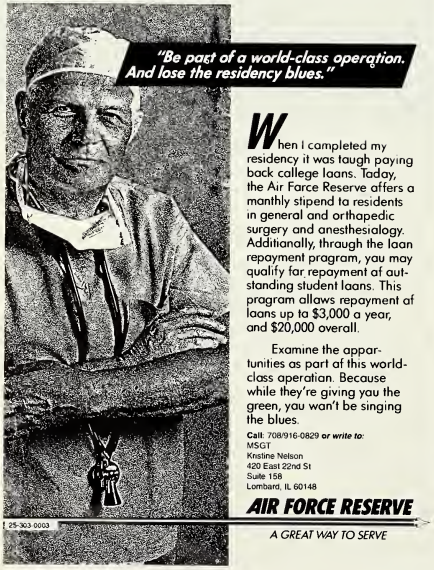
a random sample of discharges, a sample for CCP, a focused sample to allow the IFMC to concentrate on potential concerns unique to Iowa and an "equalization" sample to assure that all hospitals are reviewed.

The IFMC will continue using nonphysician reviewers to initially identify potential concerns. As now, potential concerns will be referred to same-specialty physician reviewers.

Quality review process

The existing quality intervention plan and its "point system" will be replaced with a more educational quality review process. The quality review process will identify physicians, hospitals and statewide problems and focus educational efforts to improve the quality of care to Medicare patients.

For more information about upcoming review changes, contact Diana Kading, senior advisor for provider services, at 800/383-2856 or 515/223-2146.



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A one-half hour video entitled "Practical Strategies for Improving Dietary Compliance in Hypercholesterolemia" is also available. "Practical Strategies" has been reviewed by the AMA's scientific and continuing medical education divisions and has been approved for one-half hour CME credit.

To obtain any of these free written or video materials or for more information contact the Iowa Beef Industry Council, P.O. Box 451, Ames, Iowa 50010; phone 515/232-0428; fax 515/223-5531.

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AHA and NCEP guidelines allow lean beef

The American Heart Association and the National Cholesterol Education Program have recognized the place for lean beef in a varied, balanced diet. Both of their dietary guidelines recommend up to 6 oz daily of lean beef and meats, poultry, or seafood.[3,4]

Here are guidelines that can help your patients enjoy beef that's compatible with a heart-healthy diet:

- Purchase lean cuts
- Keep portions moderate (3 oz cooked)
- Remove visible fat before cooking
- Prepare without additional fat

References:

1. Savell JW, et al. National Beef Market Basket Survey. *J Anim Sci.* In press.
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Remediation through personalized CME (Part I)

Richard Nelson, M.D.

AMONG THE MANY CONTROVERSIES confronting health care reformers is the need to link outcomes of care with physician practice patterns. There is growing recognition that the industry which has flourished under the rubric of utilization review may not be contributing much to either the quality of health care or the containment of costs. Micromanagement of physician care may be on its way out, and yet what will replace it?

Here the controversy does not abate, but a growing concensus among health policymakers suggests a physician's practice pattern should be evaluated based upon the results of care. Longitudinal review of hospitalization, surgical outcomes and even office practice is now feasible.

Early efforts in this arena, related to Medicare peer review, have identified physicians with recurring difficulties in selected aspects of medical management. Cited are the management of fluid and electrolyte balance, renal insufficiency and perioperative care. The inappropriate use of medications is an issue with some physicians, particularly antiarrhythmics, antibiotics and anticoagulants. When deficiencies in medical management have been determined, a remediation plan may be sought by reviewers to assure the physician's management of patients improves.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

Here then is the dilemma. The educational resources available for focused remediation may be scarce and certainty their use will accomplish the desired effect is absent. This statment may seem odd in light of the plethora of continuing medical education courses and activities available throughout a region or the nation, but the observation has validity for two major reasons.

Most CME courses encompass a breadth of topics in a specialty area. Presentations by experts provide an overview of a disease or condition and recommended approaches to diagnosis and management. Rarely do presenters discuss detailed management using case scenarios. Such a presentation is an educational challenge in a large group setting. The approach may be utilized, but this is done most often in a course concentrating on management of a specific medical condition, such as diabetes or hypertension. The physician who lacks contemporary practical knowledge of an aspect of management will have to be very selective in choosing an appropriate course.

Perhaps the major reason most traditional CME offerings cannot predictably assure focused remediation is that participants are not challenged to improve their knowledge through demonstration of their newly acquired learning. Physicians are requested to evaluate a course, but they do not evaluate their personal gain in useful knowledge.

This gain is at the heart of remediation.

Watch for Part II, the design of personalized CME, in a forthcoming issue.

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AAFP: This program has been reviewed and is acceptable for 6.5 prescribed hours by the American Academy of Family Physicians.

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Registration Fee: $95 includes attendance at the symposium, two free tickets for the Friends of Bix' Cocktail Party, 2 complimentary tickets for the Riverboat Gambling Cruise and 2 entries in the Bix 7 Road Race.

Registration Deadline: July 1, 1993. Confirmation and details about entertainment options will be sent upon registration. Please direct any concerns to Rebecca Gannon(319) 326-8115. Refund policy: A refund less a $25.00 processing fee if your request is postmarked by July 15, 1993.

Morning Schedule

8:00- 8:20	Registration-Continental Breakfast
8:20- 8:35	Welcome - Symposium Overview - Dr. Giudici
8:35- 9:15	"Lipid Disorders" Dr. Connor
9:15- 9:55	"Advances in the Treatment of Atrial Fibrillation/Flutter" Dr. Waldo
9:55-10:20	Break
10:20-11:00	"Renal Implications and the Treatment of Essential Hypertension" Dr. Gratch
11:00-11:40	Panel
11:40-12:55	Lunch with the Speakers

Afternoon Schedule

12:55- 1:35	"Management of Ventricular Arrhythmias" Dr. Wilber
1:35- 2:15	"New Techniques in Interventional Cardiology" Dr. Fischman
2:15- 2:35	Break
2:35- 3:15	"Non-Invasive Cardiology Update" Dr. Miller
3:15- 3:55	Panel

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PHYSICIANS & THEIR FAMILIES WORKSHOP — July 25-30, 1993. Location: Grande Butte Hotel, Crested Butte, Colorado. Credit: 24 (ACCME); 24.5 (AAFP). Contact: The Menninger Clinic, Topeka, Kansas, 800/288-7377.

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ARE YOU ONE OF THOSE physicians who wonders why you should belong to the AMA? Do you believe you don't need the AMA because you already belong to your county, state and specialty societies? I disagree wholeheartedly, and I'm about to tell you why.

As an AMA delegate and alternate delegate, I watched the AMA in action for over 19 years. I have seen the AMA House of Delegates evolve from a sea of white hair to a vibrant organization encompassing every facet of medicine. With the addition of the student delegation, the resident delegation and, more recently, the hospital staff section, the AMA is truly an umbrella organization. I don't know of a more democratic organization than the AMA. Any AMA member may speak at a reference committee hearing and many do.

Do I agree with every AMA action? No, but I also don't always agree with the actions of congress or our state legislature. However, I continue to support all three!

The AMA also provides other services such as establishing medical ethics, accrediting medical schools and residencies and maintaining a master file on all physicians in America. We all know that, if the AMA didn't do these things and do them well, Uncle Sam would.

What has the AMA done for us lately? Here is a partial listing: *February 16*—AMA meets with Ira Magaziner of the White House task force on health care reform; *February 24-26*—AMA meets again with Magaziner and HHS Secretary Donna Shalala; *March 3*—AMA meets with National Governors Association on strategies for health care reform; *March 10, 22, 23*—AMA meets with Magaziner and testifies on antitrust before the Senate Judiciary Subcommittee on Antitrust; *March 16*—AMA meets with task force addressing antitrust relief, negotiating authority, quality measurement, liability reform and medical ethics; *March 23-25*—1,000 physicians join in Washington to deliver our message to the congress and the Clinton Administration; *March 26-27*—At White House request, AMA testifies at two-day round table on health care reform.

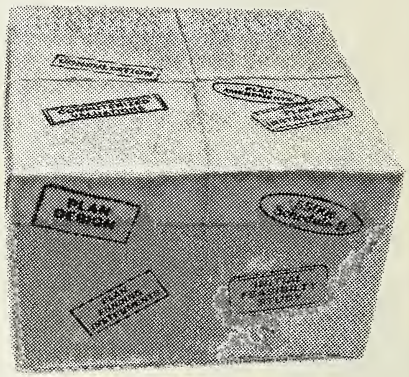
This is an impressive list which could be longer if I had more space.

The AMA is strong, vigorous and very active in speaking out for the interests of our patients and our practices. I encourage everyone to join the AMA. During the health care reform process, medicine must have one voice. The specialty societies can speak only for one segment of medicine. The AMA can effectively speak for us all.

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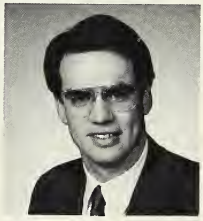
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Official proceedings, IMS 1993 House of Delegates

April 17-18, 1993

The 1993 Annual Meeting of the Iowa Medical Society House of Delegates was held April 17-18 at the Des Moines Savery Hotel. House sessions were chaired by Donald Kahle, M.D., speaker. Open hearings were conducted by three reference committees April 17. The annual banquet was held April 17 and was chaired by William Eversmann, Jr., M.D., IMS president.

IMS MERIT AWARD

At the annual banquet, John Tyrrell, M.D., a Manchester family physician, received the 1993 IMS Merit Award.

The Outstanding Medical Office Administrator Award was given to Chuck Elder, administrator of McFarland Clinic, Ames.

APRIL 17 SESSION

Registered for the April 17 session were 143 delegates. Minutes of the 1992 House of Delegates session were approved as summarized in the July, 1992 issue of Iowa Medicine.

New delegates to the House were introduced and reference committee appointments were announced.

Dr. Joseph Painter, president-elect of the American Medical Association, addressed the House. He discussed AMA efforts to work with the Clinton administration on health care reform.

Reports contained in the 1993 House of Delegates handbook were approved, with the exception of the report of the Committee on Articles and Bylaws, which was referred to the appropriate reference committee.

Two checks totalling over $20,000 were presented on behalf of the AMA-Education and Research Foundation to James Clifton, M.D., acting dean of the University of Iowa College of Medicine. It was acknowledged that nearly all the gifts came from the medical family and were recruited from physicians and their spouses by members of the Auxiliary.

REPORTS TO THE HOUSE

The following supplemental reports were submitted and referred to appropriate Reference Committees:

The IMS Board of Trustees, the IMS Executive Council, the IMS Judicial Council, the Committee on Articles and Bylaws, the Committee on Legislation, the PRO Advocacy Committee, the Committee on Forensic Medicine and the Subcommittee on Utilization Assessment.

The Necrology Report was presented by Robert Kent, M.D., chairman of the IMS Judicial Council, with delegates observing a moment of silence in honor of deceased physicians.

The report of the Nominating Committee was accepted and nominations were made from the floor for an open alternate AMA delegate slot. Nominating speeches were made on behalf of candidates for office.

Informational reports were presented from the IMS Education Fund, IMS Services, Iowa Physicians Mutual Insurance Trust, the Iowa Foundation for Medical Care and IMPAC.

Dr. Eversmann presented a special report on health care reform issues at the state and national levels, with attention to IMS activities and participation in various health care reform efforts. Dr. Eversmann also presented the traditional president's address. (An excerpt of his remarks appears elsewhere in this issue.) He was given a standing tribute for his leadership during the past year.

Fourteen policy resolutions submitted by county societies, councilor districts and others were formally introduced and referred to appropriate Reference Committees. Actions taken on these resolutions are reported subsequently.

LIFE MEMBERS

The following physicians were elected to life membership in the Iowa Medical Society (Life Members are physicians who have practiced medicine for 50 years and have been members of the IMS for 15 consecutive years):

Albert Blenderman, Jr., M.D., Spirit Lake; **Michael Bonfiglio, M.D.**, Iowa City; **Daniel Bray, M.D.**, Algona; **Charles Burr, M.D.**, Des Moines; **Alexander Bushmer, M.D.**, Orange City; **Robert Collison, M.D.**, Oskaloosa; **Hunter Comly, M.D.**, Cedar Rapids; **Hellen Deaton, M.D.**, Iowa City.

William Drier, M.D., Waterloo; **Robert Eaton, M.D.**, Clarion; **Lawrence Ely, M.D.**, Des Moines; **Edward Eneboe, M.D.**, Hawarden; **John Ferguson, M.D.**, Newton; **Charles Fesenmeyer, M.D.**, Davenport; **George Fieselmann, M.D.**, Spencer; **Walter Friday, M.D.**, Burlington.

Lyle Frink M.D., Spencer; **Wylie Griffith, M.D.**, Clinton; **W. David Haufe, M.D.**, Bloomfield; **Harris Heise, M.D.**, Marshalltown; **Walter Kasiske, M.D.**, Keokuk; **Joseph Kehoe, M.D.**, Davenport; **Herbert Kersten, M.D.**, Fort Dodge; **Paul Kersten, M.D.**, Nokomis, FL.

Kenneth Kinsbury, M.D., Sun City West, AZ; **John Krettek, M.D.**, Council Bluffs; **Paul Lambrecht, M.D.**, Des Moines; **Howard Latourette, M.D.**, Iowa City; **John Lavender, M.D.**, Sioux Falls, SD; **Richard Lawton, M.D.**, Iowa City; **Robert Lee, M.D.**, Milford; **John MacQueen, M.D.**, Iowa City; **Charles Maplethorpe, Jr., M.D.**, Toledo.

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Lewis Norris, M.D., Newton; **Robert Petersen, M.D.**, San Diego, CA; **Elroy Peterson, M.D.**, Ames; **Carol Plott, M.D.**, Mountain Home, AR; **Edward Posner, Jr., M.D.**, Des Moines; **Ignacio Ponseti, M.D.**, Iowa City; **Adrian Powell, M.D.**, Elkader; **Philip F.H. Pugh, M.D.**, Spirit Lake; **William Robb, M.D.**, Cedar Rapids.

Howard Rudersdorf, M.D., Sioux City; **Austin Schill, M.D.**, Rio Verde, AZ; **Donald Schissel, M.D.**, Des Moines; **George Spellman, M.D.**, Sioux City; **Frederic Stamler, M.D.**, Iowa City;

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John Walker, M.D., Waterloo; **G. Travis Westly, M.D.,** Mason City; **Maurice Wicklund, M.D.,** Cedar Falls; **Herbert Wormhoudt, M.D.,** Fernandina Beach, FL; **Richard Young, M.D.,** Clarion.

Emeritus IMS membership was accorded to 46 physicians.

The speaker then presented information on the Reference Committee hearings, election procedures and the concluding session of the IMS House of Delegates.

APRIL 18 SESSION

Registered for the April 18 session of the House were 126 delegates. Minutes of the April 17 session were read and approved.

Mrs. Mary Foley, immediate past president of the IMS Auxiliary, spoke to the delegates about Auxiliary projects during her term. It was acknowledged that the IMS Auxiliary will now be called the IMS Alliance.

Mrs. Mary Hanson, president-elect of the AMA Auxiliary, also addressed the delegates.

The following physicians were announced as having been elected or reelected to the positions noted:

President-elect: **James White, M.D.,** Dubuque.

Vice-president: **John Brinkman, M.D.,** Mason City.

Speaker, House of Delegates: **Donald Kahle, M.D.,** Dubuque.

Vice Speaker, House of Delegates: **Tom Throckmorton, M.D.,** Spencer.

Trustee: **Harold Miller, M.D.,** Davenport.

AMA Delegates: **Clarkson Kelly, Jr., M.D.,** Charles City and **William Rosenfeld, M.D.,** Mason City.

AMA Alternate Delegates: **R. Bruce Trimble, M.D.,** Mason City; **Daniel Youngblade, M.D.,** Sioux City and **Thomas Graham, M.D.,** Iowa Falls.

Six District Councilors were also chosen during annual elections: **Siroos Shirazi, M.D.,** Iowa City (District II); **Albert Coates, M.D.,** Cedar Rapids (District IV); **Ross Madden, M.D.,** Dubuque, (District V); **Don Green, M.D.,** Des Moines (District X); **C. David Smith, M.D.,** Des Moines (District IX); and **Stephen Richards, D.O.,** Algona (District XIV).

The speaker acknowledged the efforts of the Reference Committees. Following adjournment of the House of Delegates, John Anderson, M.D. of Boone was installed as president of the IMS for the coming year. His inaugural comments are published elsewhere in this issue.

Organizational meetings of the IMS Board of Trustees and Judicial Council occurred following Dr. Anderson's installation.

HOUSE OF DELEGATES POLICY ACTIONS

The IMS will take the following actions based on House of Delegates consideration of reports from three reference committees. The committees included the **Reference Committee on Medical Service** chaired by John Redwine, D.O.; the **Reference Committee on Legislation and Miscellaneous Business** chaired by Wilson Davis, M.D.; and the **Reference Committee on Reports of Officers/Articles of Incorporation and Bylaws** chaired by Mary Hoppa, M.D.

•Ask that HCFA designate the state of Iowa as a single Medicare payment locality.

•Encourage development of basic health insurance policies free from mandates and comprehensive requirements.

•Oppose discriminatory benefit limitations, copayments or deductibles for treatment of psychiatric illness under existing health care plans and oppose discrimination in any proposed plans for national health care coverage or universal access for uninsured people.

•Support AMA policy to seek legal or legislative opportunities to clarify that Section 1867 of the Social Security Act applies only to inappropriate transfers from hospital emergency departments and not to issues of professional medical liability.

•Consider the feasibility of establishing a statewide IPA.

•Work with the AMA to eliminate or change CLIA and OSHA regulations.

•Commend physicians who provide care to indigent patients.

•Urge the UI College of Medicine to proceed as rapidly as possible to appoint a permanent dean.

•Consider a variety of times for CME and practice management/risk management seminars and give as much advance notice of programs as possible.

•Seek modification of antitrust laws to permit physicians to work together in the best interest of patients and support AMA attempts to seek relief from federal antitrust laws.

•Support extending the partner notification plan to include identifiable partners of decedents who are HIV positive.

•Review Iowa laws relating to HIV/AIDS and make recommendations for legislative changes to make these laws more consistent with current public health practices for control of other communicable diseases.

•Affirm support for AMA policy that decisions on excluding immigrants to the U.S. be based on the best medical and public health information and recommends mandatory HIV testing for all immigrants.

•Oppose President Clinton's proposal to remove HIV from the list of communicable diseases of "public health significance" for purposes of immigration law. (This resolution will be sent to the president and the U.S. Department of Health and Human Services.)

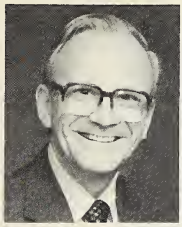
•Accept the Board of Trustees recommendation that IMS dues for 1994 be raised $10 to $380 per member.

•Approve four strategic planning priorities including redesigning IOWA MEDICINE to include material now put into newsletters; determine what data the IMS will need in the future to remain a viable advocate for Iowa physicians; upgrade the membership data base; and strengthen the judicial councilor system to better represent physicians in county medical societies who are not currently active.

•Amend its bylaws to permit deputy councilors to attend and vote at Executive Council meetings if the Councilor is unable to attend.

•Amend its bylaws to implement a district wide election procedure for Councilors.

•Amend its bylaws to impose term limits on the offices of Speaker, Vice Speaker, AMA Delegate and AMA Alternate Delegate.



Marion E. Alberts, M.D.

Steer kids away from smoking

A RECENT PUBLICATION BY THE American Council on Science and Health, Inc. discusses harmful tactics of tobacco companies in marketing cigarettes to children and minors. Tobacco addiction may be considered a childhood disease because children begin smoking at an average age of 13 years. Our youth are illegally consuming 947 million packs of cigarettes and 26 million containers of smokeless tobacco per year.

Why do youth embark upon the use of tobacco when it is common knowledge smoking is a health hazard? Many young people who indulge in binge drinking, careless driving, use of drugs and sexual activity do so because they believe they are invincible. They have an "it won't happen to me" attitude. Because of this attitude, cigarettes direct attention to recruiting new smokers through innuendo and deceit.

Advertising of cigarettes appears in magazines read by youth. Covert cigarette promotions appear in many motion pictures which attract the youthful audiences. Forty percent of all movie goers are under age 21.

Cigarette advertising enters the athletic arenas as well—e.g., Virginia Slims tennis tournaments. Once it was the Marlboro man; now Joe Camel has become a blatant example of marketing tobacco products to children. The cool, smooth character of Joe Camel, always with a cigarette in his hand, implies smoking is an essential part of his youthful and glamorous lifestyle.

We of the medical profession have a special responsibility to counsel our young patients of the apparent deceit being perpetrated by the tobacco industry. We know smoking is a health risk; we must inform our young patients. Illegal sales of a single brand of cigarettes amounted to $476 million in 1990. Over half of high school seniors who smoke become addicted. Because 90% of new smokers begin by age 19, the future of tobacco industry profit depends on attracting youth.

The facts are startling. A copy of "Marketing Cigarettes to Kids" is available through ACSH (1995 Broadway, 2nd Floor, New York, New York 10023-5860) for $3.85 (postage and handling included).

Readers, be aware of the marketing strategies of the tobacco industry. Help our youth reject the use of tobacco.

Physicians must remain committed to beneficial reform

Health care reform is on the horizon, and physicians must stay committed to reform that benefits patients. This is the message from William Eversmann, Jr., M.D., outgoing IMS president, and John Anderson, M.D., newly installed president. Excerpts from their remarks to the 1993 IMS House of Delegates are reprinted here.

William Eversmann, Jr., M.D.
Cedar Rapids, Iowa

WITHIN A FEW WEEKS, Clinton and Clinton will reveal to us their concept of reform of the health care delivery in this country. President Clinton's plan will feature cost-containment in two forms—the long term cost savings and the immediate cost savings.

The cost controls that will have effect over many years (but not until restructuring at the cost of $60 billion has occurred) will include insurance reform to increase availability, portability and renewability of health insurance, tort reform, managed care that promotes wellness, preventive medicine and managed competition or what is to be called "community health alliances" to structure health care delivery.

The immediate cost controls will be produced by price controls, price reductions and extension of Medicare payment rates to private insurance, all of which can be contained within the terms "global budgets" and "expenditure targets."

Let's look at the effect of health care price controls in Britain, Canada, Germany and Japan to compare with what could occur here.

One of the first effects of price ceilings on the delivery of health care will be shortages of goods or services and costly or unpopular methods of allocating goods and services such as queing, rationing or even bribes. We know this has occurred in Britain's National Health Service, which has had fixed budgets and prices since the early 1950s. One million Britons now wait for care, which would be equivalent to five million Americans. A quarter of a million Canadians are waiting for care at any one time, which would be equivalent to 2.5 million Americans.

In Japan, there has been a tremendous increase in volume of medical care. In the U.S., a senior citizen would have 3.6 visits per 6-month period; in Japan that same senior citizen would have 17.3 visits in 6 months. Another common effect of price controls is that the well-connected and richer consumers benefit at the expense of others. We have seen this in the Canadian system when Canadian politicians are regularly receiving care in either Detroit or Buffalo, abandoning their clogged system to seek high quality care in

this country while the less affluent must endure the long waiting in Canada.

Shortages, black market exchanges

Price controls can also encourage black market exchange of goods and services. We have seen interesting examples of this in the Japanese health care delivery system.

The Japanese have four separate health systems. There is the national health insurance system which covers approximately 37% of the Japanese. A second system comprised of 1,900 employer-based health plans covers the remaining 63%. There is also a university health system which provides the highest quality care in Japan and a foreign health care system which is used almost exclusively by foreign nationals in the larger metropolitan areas. In the Japanese system, price controls have reduced quality, increased use of the system and led to inefficient use of resources. In the case of black marketeering as the result of price controls, the Japanese have a peculiar system arising from a fee schedule which gives uniform payment to all providers. At the university hospitals, long waiting lists must be endured for high quality care. To avoid these lines, a monetary gift of between $1000 and $3000 (American) can be

'It continues to be vital that we physicians inform our patients of the effect of price controls, if they are proposed, on the delivery of health care in this country and this state.'

provided to an attending doctor at a university hospital by a patient choosing a private room for an inpatient evaluation or treatment. The patient then is treated by a senior specialist within the university system and receives quite high quality care.

Another effect of price controls is that the longer they are in force, the more serious the shortage of goods and services will become and the more painful the adjustment process back to any market prices. The British system is certainly the oldest of the national health care systems which have price controls. In 1991, the British attempted to eliminate the long wait for health care, which



William Eversmann, Jr., M.D. (right), IMS immediate past president, congratulates his successor, John Anderson, M.D.

for some patients was well over two years. In April of 1992 the number of people on the two-year waiting list had been reduced by 97%. But the overall time of all patients waiting for care had been reduced by just 3%. The cost of this tremendous effort to the National Health Service budget was a 13% increase in spending. Also, price controls reward those who "game" the system and penalize those who do not. In Canada, health care spending as a percentage of gross domestic product is the second highest in the world and has a growth rate identical to that of the U.S. With price controls in Canada there are growing waiting lists and hospitals are eliminating beds, shutting down departments and laying off staff to meet their budgets.

At the same time Canada has a 5.2% higher rate of hospital admissions than does the U.S., 29% more hospital beds per 1,000 population, 27% higher bed occupancy and the lengths of stay are 52% longer.

It is really simple. In the Canadian system, more patients mean more revenue for the hospital. The budget which is fixed by the government is maintained by the hospital by keeping recuperating patients who cost less to care for and by keeping out sick people whose care is more expensive. This technique is known in Canada as "bed blocking."

In Germany the number of physician contacts per capita per year is 11.5. In the U.S., it is 5.3 visits per year. German hospitals are paid the same fixed per day rate regardless of illness or treatment and consequently have more than double the number of beds per

(Continued next page)

1,000 population. Similarly, the length of stay in Germany is 12.7 days per hospital stay as opposed to 7.2 in the U.S. In our own Medicare system, we have seen some of the same "gaming" and manipulation of the imposed system by the response to price controls within the Medicare system which already exists.

We have seen for instance un-bundling of surgical fees, up-coding of patient visits, and in response to the up-coding the trashing of an entire coding system and instituting an entirely new coding system to try and control the up-coding used by physicians to increase their fees.

Still another effect of price controls is the diversion of economic activity and investment from heavily controlled sectors into less controlled or uncontrolled sectors. We have ample examples of this within our Medicare system where government imposed fee controls have been compensated for by cost shifting from private insurance, a clear diversion of economic activity. Since it appears that price controls will in some way affect the drug-producing companies or phramaceuticals themselves, we can expcect reduced research and development of pharmaceutical drugs.

It continues to be vital that we physicians inform our patients of the effect of price controls, if they are proposed, on the delivery of health care in this country and this state. Patients must be kept informed of the implications of those reforms proposed by the Clinton Administration so they can exert their influence with government concerning those reforms.

Remain committed

At the same time, we must continue to be committed to well structured health care reform which is of benefit to our patients. We can expect these discussions will go on for months or years to come and we must be prepared to continually provide our patients with perspective and courses of action so their health care delivery system does not fall victim to the politicians that have controlled the Canadian, British, German or Japanese health care delivery systems. To do less would not be responsible to our profession, to ourselves or to our patients.

Thank you again for the honor of electing me president of this society and for supporting me during my year of leadership.

John Anderson, M.D.
Boone, Iowa

I THANK THE HOUSE OF DELEGATES for electing me. This truly is a high point in my career. I also thank Bill Eversmann for his leadership during the past year. He has been a tireless spokesman for Iowa physicians and we owe him a debt of gratitude.

Last month I spent two days in Washington at the AMA's Time for a New Partnership. We listened to many leaders of congress and the vice president. We spoke to our own congressmen. No one knows what Mrs. Clinton is going to propose to the President, but there was great trepidation regarding what might be coming.

With all the chaos and confusion surrounding health care reform, physicians all over America will be making many hard decisions. In making these decisions, I believe there are three absolute essentials we must not forget.

Everyone can win

The first is we must put our patients first in every decision we make. This is easy to say but very difficult to do. In the health care reform process, we will be the only real advocate our patients have. Our government and the insurance industry are going to be more interested in bottom lines than taking care of people. Although we must look out for ourselves, we must never serve ourselves first and patients second. I believe if we continually strive to do what is best for our patients, we will have their support and everyone will come out a winner.

The second essential is involvement. Needless to say, your IMS officers and staff will be very involved in health care reform. This will be our number one priority during the coming year. However, they can't do it alone. We need everyone of you here to do whatever you can to get physicians at home involved. We will need all the help you can muster and I am counting on you folks to really stir the troops up at home. We will also need the involvement of our families, including members of the IMS Alliance, formerly the Auxiliary.

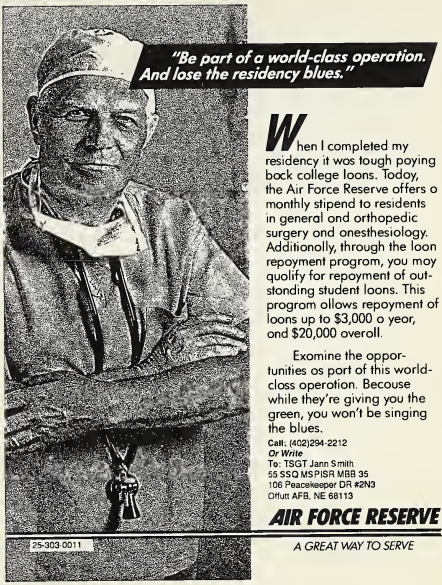
The third essential on the road to health care reform is unity. The president has stated that everyone will have to sacrifice. That means everyone's ox will be gored, some

more than others. This one fact alone can split our Association.

Cuss and discuss

There are probably as many opinions on how to solve the health care crisis as there are members of the Iowa Medical Society. Someone said that leading a group of physicians is like hearding a flock of chickens. As physicians, we have been taught to be independent thinkers and diversity of opinion is good. However, the place to cuss and discuss our differences is in the House of Delegates, not with the press or in public. After thorough debate, we must choose a course of action and support it. If other major players in health care reform see us as divided, I shudder to think of the possible outcome. Organized medicine at all levels must work hard to keep the house of medicine together. It will be a tremendous challenge, especially for the AMA.

As professionals acting like professionals, we will be successful in helping reshape health care delivery in Iowa. The challenges confronting patients and doctors are going to be the most critical in at least a generation. These same challenges provide a tremendous opportunity for us to shape medicine for the 21st century.



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Yes, there is life outside of medicine! On these two pages, 1993-94 IMS board members answer thought-provoking non-medical questions







	John Anderson, M.D. **IMS president** Age 57; Family practice U of I College of Medicine	**James White, M.D.** **President-elect** Age 60; Otolaryngology U of I College of Medicine	**Joseph Hall, M.D.** **Board chairman** Age 57; Radiology U of I College of Medicine
Q **Where do you practice and why?**	I've practiced in Boone since 1967 because it has a good hospital and is a great place to raise a family	I've practiced in Dubuque for 27 years... it's my home county and I like the river and the hills	I've been in Des Moines at Radiology P.C., Iowa Methodist Medical Center, since 1969
Q **Do you have children? (grandchildren?)**	3 sons — Jeff, Todd and Kip; 2 grandsons — Regan, 2 and Erik, 4 months	We have four sons and one daughter	We have a daughter Elizabeth who's a lawyer and a son Patrick, a student
Q **What is your favorite hobby or pastime outside of medicine?**	Boating at our cottage at Twin Lakes, fishing, golf and playing with my grandsons	The conservation side of farming and wildlife, which is the barometer of clean water and food	Watching and reading about baseball, hiking, movies, jazz and classical music, a *little* gardening (especially growing pumpkins)
Q **What is the last book you read?**	*The Client*	*A History of the Middle East* by Peter Mansfield	*The Man in the Dugout*
Q **If you hadn't become a physician, what would you have done?**	I worked in drug stores from the 6th grade through undergraduate school and might have become a pharmacist	I would have chosen farm management because it is fun to plant seeds under different conditions and watch the miracle of growth	My eyes wouldn't qualify me to be a pilot, so I'd say law combined with business, emphasis on reål estate
Q **If you won the lottery, what would you do?**	I would retire and take a trip around the world	I would narrow my practice, buy an Iowa ranch and raise a herd of pure bred cattle	Invest my winnings, give some to favorite charities and keep on practicing radiology
Q **What person from history would you most like to invite to dinner?**	Ben Franklin and Samuel Clemons because they would make extremely good conversation around the table	General Patton because I want to see such a pompous person interact with people, Teddy Roosevelt because he was a man who got things done	Einstein for scientific perspective, Christ for religious philosophy, Thomas Jefferso and a player to be named later for political views









William McMillan, M.D. **Board secretary/treasurer**	**Harold Miller, M.D.** **Trustee**	**John Brinkman, M.D.** **Vice president**	**William Eversmann, M.D.** **Past president**
Age 46, Otolaryngology University of Michigan	Age 45, Family practice U of I College of Medicine	Age 56, Internal medicine U of I College of Medicine	Age 55, Orthopedic surgery University of Pittsburgh
I have been in Ottumwa for 15 years because of the "small town" life with a large practice	Practiced in Davenport since 1977...congenial medical community, good schools with good classical music programs	I've practiced in Mason City since 1969...it's a stable community with good medical facilities and physicians	I served 20 years in the U.S. Army (retired colonel) and have practiced in Cedar Rapids for 10 years
We have 3 daughters ages 10, 12 and 14	Eric 22, Bradley 22, Jana 19 and Cathleen, Emily and Christine, all 10 years old	We have 3 children	Two daughters — Karen, 22 and Susan, 27; 1-year-old granddaughter, Gwendolyn
Sailing — We have a cottage in Michigan where our family has vacationed for generations	Gardening and landscaping — shrubs, perennials and annuals — with care to attract wildlife	Cooking	Boating on the Mississippi, raising orchids in my year-round greenhouse, photography and collecting cameras
Gai-Jin by James Clavell	*Compelling Evidence* by Steve Martini	*Gate of the Tigers* by Henry Maigs	*Bankruptcy, 1995*
Teaching and research because I enjoy watching minds grow and mature	Organic chemistry research because the challenges of problem-solving are numerous	I would have become an organic chemist	I would have become an engineer or pursued a career in mathematics
Start a foundation to sponsor a new method of medical documentation	I'd continue practicing but I'd devote more time and money to political developments adversely affecting our patients and the practice of medicine	I would take more vacations	I'd retire to pursue hobbies and interests associated with medicine...maybe go back to school
Thomas Jefferson to discuss how a new nation was created, Caesar to discuss truths which survive today and Thomas Edison	Albert Einstein to explore his views of modern science and Oliver Wendell Holmes for his views of fairness and personal responsibility	Abraham Lincoln Ghandi Thomas Jefferson	Jesus Christ, the head of my church, for many reasons; George Patton and Abraham Lincoln



Judy Hoenk

New goals for Alliance

The author, newly installed president to the IMS Alliance (Auxiliary), discusses the organization's new name and new goals.

Why has the IMS Auxiliary changed its name to the IMS Alliance?

We felt that "Auxiliary" projected the wrong message and was hurting our membership recruitment. To many, the word auxiliary identified us as a women's organization. One definition for "alliance" is "a close association for a common objective." We feel this better defines the relationship we want to have with the IMS.

How has the IMS Alliance changed in recent years?

The increasing number of women in the work force has drastically affected our organization. Over 50% of medical school students are now female and that means we will be recruiting their husbands for membership. We are also seeing a tremendous increase in female spouses with careers of their own. Both of these groups have limited time available for volunteer activities.

We are in the process of reassessing our organization to meet the needs of our changing membership. As an advocate for medicine and an organization concerned about the pressures unique to the medical family, I feel we can continue to serve our entire membership.

Tell us about two or three key projects which the Alliance will undertake during the coming year?

Youth support cards will be our first project. These are billfold-size cards containing crisis numbers for teens to call for help and counseling. The cards will be laminated and will contain 800 numbers so they can be used throughout the state. We plan to have 100,000 printed which will be distributed

through the school system in the fall. We will also offer the cards to physicians for their offices. This is a joint effort with the IMS, which funded the printing of the cards.

Health care legislation is an increasing priority for us. The mini-internship program, another joint project with the IMS, will be continued. A long-term goal is to extend the program to include members of the media. We also plan to keep our own members informed and will include articles about legislative issues in our newsletter.

What are your goals as president of the IMS Alliance?

As spouses I feel we should be leaders in promoting healthy lifestyles. Through our health education and community service projects we can enhance the image of medicine. Working together with the IMS we can each become better advocates for the medical profession. Active county alliances are the key to strengthening our organization and I plan to work closely with each county.



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A look back: House of Delegates 1893

FROM THE PROCEEDINGS OF THE *Forty-second Annual Session of the Iowa State Medical Society, held at Burlington, Iowa, May 17th, 18th and 19th, 1893:*

"The Committee on Ethics reports in regard to the charges brought against Dr. F. B. Dorsey, that in view of the fact that he has apologized in writing for his indiscretion in advertising, promising to destroy the remaining advertising cards and refrain from such unethical proceedings in the future, the Committee therefore recommends that he be admitted as a member of the Iowa State Medical Society."

S/
George F. Jenkins
D. S. Fairchild
D. W. Crouse
I. S. Bigelow
D. Macrae

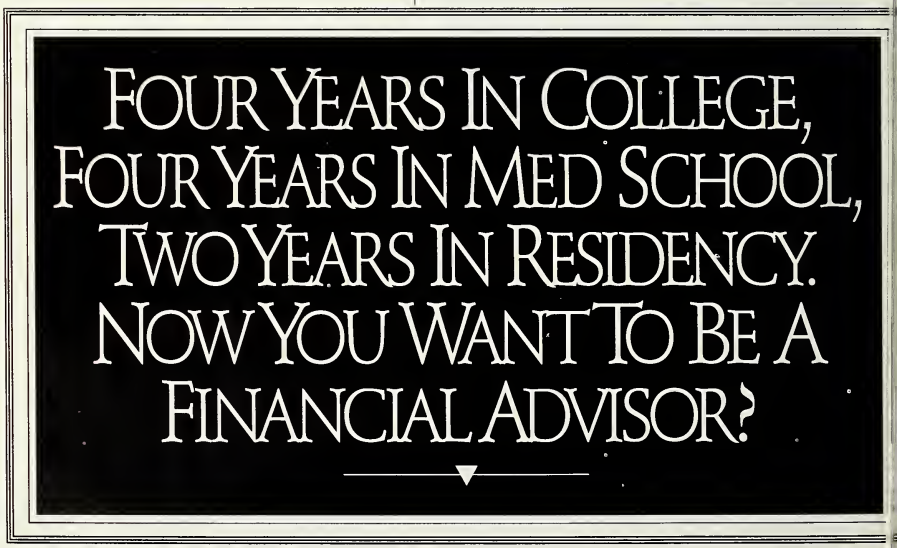
Dr. Dorsey's statement (May 17, 1893):

"To the President and Members of the Iowa State Medical Society: Gentlemen: I hereby acknowledge that the matter in which I had printed and distributed my professional cards in Keokuk, Iowa was in violation of the spirit of the Code of Ethics of your Society, and I shall at once use every endeavor to have the same suppressed, and shall refrain from repeating the same in like offense in the future."

S/
F. B. Dorsey

Report from the Committee on Publications:

"The following is the proposition offered the Iowa State Medical Society: The Omaha Clinic will publish complete by January 1st, 1894, separately paged, the transactions (minutes, papers and list of members) for Two hundred ($200) Dollars. Also any number of fifty or more bound volumes uniform in size and form with those of the years 1891 and 1892 at cost (estimated at 75 cents); Provided,



orders are left with the secretary by July 1st, 1893. And a copy of the *Clinic* will be sent for one year, i.e., from July 1st 1893 to July 1st 1894, to each member of the Society.

One hundred Dollars to be paid by September 1st 1893 and One Hundred Dollars to be paid by January 1st 1894."

S/
George Wilkinson, M.D.
Editor of *Clinic*
per F. S. Thomas

Editor's Note:

Dr. Thomas, in discussing the proposition, commented on the *Clinic* as "a great medical journal, in this our extensive West; its circulation is over three thousand copies each month, and is read by the leading physicians all over the Western country; its exchanges go over the world."

How times change! Imagine a copy of the transactions and an annual subscription to the *Clinic* for 75 cents!

This proposition was adopted.

Iowa State Medical Society, G. R. Skinner, Treasurer, 1892-93:

Cash on hand, as per last report	$640 50
Cash received during the year	302 80
Cash received from members at Burlington, May 17, 18, 19	150 00
Cash received from 43 delegates	129 00
Total	$1,222 30

Cost of 1893 Annual House of Delegates meeting from the Committee on Arrangements:

Expense for use of meeting hall	$30 00
Three pages three days @ 50 cents per day each	4 50
Printing programmes	6 50
Stationery supplies	3 35
Two painted canvas signs	2 50
Lumber for platform	4 53
Rent for chairs, tables, etc	6 00
Rent of cuspidores	74
Total	$58 12

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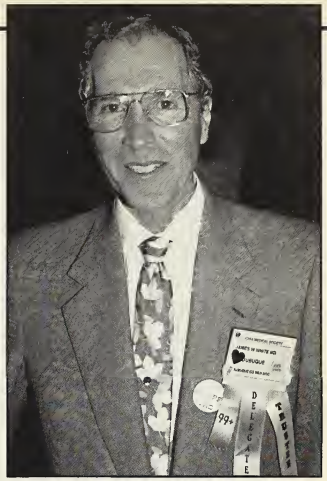
Clockwise, from left: PHOTO 1 Richard Gloor, M.D. (at left) chats with Julius Conner, M.D.; PHOTO 2 Congressman Fred Grandy (at left) with John Fieselmann, M.D. and Stephen Wolken, M.D.; PHOTO 3 Sherry Bulten, M.D. and Susan Perry, M.D.; PHOTO 4 Mary Hoppa, M.D. gives a reference committee report to the House; PHOTO 5 (from left) Dr. and Mrs. John Anderson and Dr. and Mrs. William Eversmann, Jr. at the President's Reception Saturday evening.

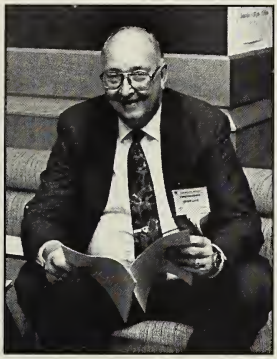














Clockwise, from above: PHOTO 1 Donald Rodawig, M.D. relaxes between sessions; PHOTO 2 IMS Life Members (at left) Dr. and Mrs. Lewis Norris and Dr. and Mrs. John Ferguson; PHOTO 3 James White, M.D., IMS president-elect; PHOTO 4 The Des Moines Children's Chorus entertained at the annual banquet; PHOTO 5 (from left) Dr. William McMillan and Dr. Donald Young visit with Dr. Joseph Painter, AMA president-elect.



Letter to the Editor

Health care should be subject to cost constraints

To the Editor:
I was disappointed in Dr. John Anderson's views as expressed in the President's Privilege in the June issue of *IOWA MEDICINE.*

Regarding health care reform, he would disallow cost considerations and opposes "trying to operate within global budgets set by people who know nothing of day-to-day patient care."

Consider how we happen to find ourselves in this situation. Not too many years ago the health care delivery system was under the control of professionals, primarily physicians. We had the opportunity then to demonstrate our ability to provide quality care at reasonable prices and for many years we did just that. Then the unions forced employers to provide insurance which paid "usual, customary and reasonable" charges, rather than indemnifying the insured a fixed dollar amount for a given service and costs began to escalate. As health care professionals, we had ample opportunity to hold costs down and failed. Having repeatedly shown we were unwilling to or incapable of controlling costs, it was inevitable that employers, insurance companies and government agencies would wrest control of the system from us.

We will never be listened to if we continue with the attitude "costs be damned." I'm sure Dr. Anderson feels free to criticize our state and federal governments for their inability to live within their means, but how can he in honesty do so if he feels health care should not be subject to some cost restraint.

Many cost-benefit analyses are already available. Others are being developed. We can't afford to provide all services to all persons everywhere. As far as health care is concerned, our goal ought to be to provide care which is cost effective and stop wasting money on care which is not.—*Karl Jauch, M.D., Waterloo.*

'Coming Together' theme undergirds MMIC's July arrival in Iowa

THE MERGER OF Midwest Medical Insurance Company (MMIC) and Iowa Physicians Mutual Insurance Trust (IPMIT) takes effect July 1, 1993. A special four-page supplement in this issue of *IOWA MEDICINE* reviews the merger process and supplies information on MMIC coverage for Iowa physicians.

In addition, May and June communications have been sent to the 1,200-plus IMS member physicians insured by IPMIT advising them about conversion to MMIC. The physician-owned MMIC promises the same quality service delivered by IPMIT. Moreover, MMIC expects to add new coverage features.

Particularly pleasing to IPMIT physicians converting to MMIC—as well as others open to considering MMIC—is the announcement of a rate reduction averaging nearly 5%.

Five Iowa Medical Society representatives become MMIC directors this month. They are William Eversmann, Jr., M.D., Cedar Rapids; Norman Rinderknecht, M.D., Des Moines; R. Bruce Trimble, M.D., Mason City; Daniel Youngblade, M.D., Sioux City and Eldon Huston, IMS executive vice president, West Des Moines.

Iowa policyholders will be serviced from MMIC offices at IMS headquarters in West Des Moines. IMS Services is being retained by MMIC to perform assigned agency duties. Inquires may be directed to either MMIC or IMS Services.

Your colleagues want to hear from you!

It's important for Iowa physicians to share opinions about current health care issues. If you have a comment regarding something you've read in IOWA MEDICINE or an issue affecting the practice of medicine in Iowa, don't keep it to yourself. It's very easy to share your thoughts in a letter to the editor.

Clozapine shows promise in schizophrenia treatment

Clozapine represents the first significant advance in the pharmacotherapy of schizophrenia since development of phenothiazine antipsychotic drugs in the 1950s and 60s, yet only about 10% of potential patients nationwide are taking the medication.

CLOZAPINE REPRESENTS a significant advance in the pharmacotherapy of schizophrenia. Treatment refractory symptoms including delusions, hallucinations and social deterioration have responded to this new, "atypical" neuroleptic.

Clozapine appears to not produce tardive dyskinisia and has a low propensity for extrapyramidal side effects. However, several cases of agranulocytosis in Finland in 1975 temporarily suspended Clozapine development in the U.S. The drug was given FDA approval in 1990.

Clozapine has been offered as an alternative to traditional pharmacologic treatment for schizophrenia at Broadlawns Medical Center (BMC) for 16 months. This article describes the development of a Clozapine treatment program and experience with 44 persons taking Clozapine in inpatient and outpatient settings. Because of the high cost and other factors, test patients were carefully screened. Initial implementation of Clozapine therapy was available to inpatients only.

Contributors to this article were: Robert Smith, M.D.; Mary Sukowatey, R.N.; Kathy Solko, A.C.S.W.; Joan Christensen, A.C.S.W.; Juliann Saak, R.N. and Anne Burnham, M.S.W., all with the Clozapine Clinic, Broadlawns Medical Center, Des Moines.

Existing staff utilized

Clozapine treatment began in June, 1991, utilizing existing staff who had experience with chronic schizophrenics. Anticipating that Clozapine would provide several patients the opportunity to live independently, an outpatient Clozapine clinic was added to monitor and support the clinical gains achieved, assure medication compliance and obtain a weekly blood sample for monitoring the white count. Through this option, many patients have been able to avoid hospitalization entirely. Peer support provided by the group assists clinic patients through the first several weeks when symptoms are not yet controlled and skepticism regarding the medication change is pronounced.

The outpatient clinic is held weekly for two hours. Patients are encouraged to discuss any issues, problems and progress with peers and staff. Group size is limited to eight to 10 patients.

Upon completion of the session, laboratory results are available and medication refills are distributed. Abnormalities in lab results are reported immediately to physicians and prescriptions are held pending physician ap-

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR JULY 1993

proval. Weekly clinical recording is entered into the patient record by program staff.

Education is vitally important to the success of any Clozapine program. Due to the severity of illness in these patients, repetitive teaching is necessary. Information must also be provided to family members and other supportive persons.

Treatment continues

There have been 44 patients on Clozapine at BMC since the first patient was started on an inpatient basis in June 1991. Of the total number of Clozapine patients, 11 were started on an outpatient basis through the Clozapine Clinic and 33 were started as inpatients.

Of the 44 patients in the program, 37 patients are diagnosed with schizophrenia (paranoid type—25; disorganized type—5; undifferentiated type—7). The remaining seven patients are diagnosed with schizoaffective disorder.

There are nine patients no longer working with the Clozapine program at BMC. Five have moved from the area but are continuing with the medication. There was one death, unrelated to Clozapine. Three patients would not take the medication as prescribed and it was discontinued.

'In our experience, Clozapine appears to fulfill its clinical promise. Previously treatment refractory patients are significantly responding and the quality of their lives is dramatically improved.'

The program currently involves 35 patients, eight inpatients and 27 attending outpatient Clozapine clinic. Of the 24 patients who started Clozapine as inpatients at BMC, 16 have been discharged to less restrictive settings.

Only two of the patients who were discharged were rehospitalized.

Of the 11 individuals who began Clozapine therapy on an outpatient basis only one has had to be hospitalized. The others have been successfully monitored on an outpatient basis. At the time of their enrollment, four lived independently, five lived in supervised group settings and two resided with family at the time their Clozapine therapy was begun. Currently, of the total outpatient clinic population (27), 11 individuals live independently, 12 live in supervised group settings, three live with family and one resides in an unlicensed board and room facility.

The increasing number of patients living independently reflects Clozapine's therapeutic ability in severely mentally ill patients.

Benign side effects

Patients have experienced many of the expected, yet benign, side effects such as excessive salivation, night sweats, GI irritation, sedation, throat irritation, fever and malaise. Almost all patients in the program have experienced substantial weight gain.

Sedation is improved with the administration of meds one time per day at supper time. This approach also minimizes GI irritation. Excessive salivation has been treated somewhat successfully with Benztropine Mesylate. Choline Salicylate and Magnesium Salicylate has been utilized for minor throat irritation.

The more serious side effects encountered by patients taking Clozapine include agranulocytosis, seizures and cataplexy (sudden transient loss of muscle tone). None of the 44 Clozapine patients treated have experienced agranulocytosis. Three patients were on anti-seizure medication prior to Clozapine for pre-existing conditions and four patients (9%) experienced seizures subsequent to Clozapine therapy and were put on anti-seizure medication. Three patients experienced cataplexy prior to seizure development.

It appears that cataplexy often precedes the development of seizure activity. Administration of Lorazepam immediately upon recognition of cataplexy has prevented seizure activity.

Patient compliance and reliability are very important. When patients are non-compliant dosages must be greatly reduced when medication is resumed. This will prevent extremes of sedation and/or episodes of cataplexy. The use of dose packs has been beneficial for patients with cognitive deficits.

Typically behavioral improvement is seen for the first three months. Psychiatric symptoms may still exist but are reduced. This obvious improvement has been followed by a period of decline in behavioral functioning and symptom breakthrough. At this point it is im-

portant to continue titration of dosage which usually results in slow but consistent improvement for a year or more.

Successful program

The program has been very successful for several reasons. Patients who have not responded to other antipsychotics have responded to Clozapine in unexpected proportions. For most patients a dramatic and startling change in affect and behavior is seen almost from the start. Only with Clozapine have these perpetual hospital patients been able to sustain some freedom and normalcy in the community.

In our experience, Clozapine appears to fulfill its clinical promise. Previously treatment refractory patients are significantly responding and the quality of their lives is dramatically improved.

However, it is estimated that only 10% of potential patients nationwide are taking this antipsychotic. Because of potentially serious side effects and bureaucratic requirements, many physicians are not utilizing Clozapine.

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Consideration, mutual respect are vital in the workplace

THERE IS EMPHASIS TODAY on quality in the service you offer your patients and in the relationship you build with your support staff.

Positive relationships require patience, consideration and an understanding of the other person's needs and beliefs. Thoughtful actions, compliments and respect give wonderful returns.

According to the American Heritage Dictionary, support means to be capable of bearing; withstand, to endure, tolerate, keeping up a person's spirit in time of stress.

The major role of the support staff is to aid the physician in carrying out his or her medical practice procedures. But what about the physician's support of the staff?

How important is your support staff to you? Take the time to consider each person. What does he or she contribute? Can you practice without them? If you want loyalty from your staff, begin by building communication. Respect each of them for their contributions to making your practice a success and your day run as smoothly as possible. People who feel appreciated will be loyal employees and coworkers. Relationships cannot be established without communication. Spend some time every week communicating with each of your support staff.

When you or your business manager hire an employee, you hope it will be a long-term relationship. There is an unspoken commitment to each other to uphold certain job duties. As in all relationships, there has to be an understanding that sometimes people have a bad day or don't feel well. Are we sympathetic to feelings, or do we return with impatient body language or even worse, a verbal comment?

As a business manager of a medical office, I can't stress enough the difference that can be made in completion of daily tasks when equal consideration is given by both the physician and the support staff.

If we would take the time to view each individual as someone with whom we wish to share a commitment, our attitude will be more positive. Adopt the team perspective. It will improve morale and enhance performance of the entire staff. Exude a positive attitude.

'Relationships cannot be established without communication. Spend some time every week communicating with each of your support staff.'

It is said that a positive mental attitude, as well as a sense of humor, has a bearing on good physical health. We are in this business to promote good health. Start with our coworkers, building a special relationship of trust and commitment. Respect and communicate, treating our coworkers with respect and consideration for all their needs, to have and uphold, through thickness and thin, "Until Retirement We Part."

Rosanna Brammer, an IMGMA member, has served as business manager at Clarke Medical Clinic in Osceola for six years.

Therefore choose life

Richard M. Caplan, M.D.

AN ESPECIALLY DIFFICULT PROBLEM in medical ethics and in the lives of physicians, nurses, patients and families is the decision to abate treatment efforts when the patient is dead, or nearly so. The medical and legal definitions of death now used in the United States clearly include brain death, so when the brain is dead the patient is dead, notwithstanding movement of lungs, heart and blood via technological help.

Greater problems arise when the neurological criteria of death are not met and the patient exists in the medical limbo called "persistent vegetative state." It is especially in this setting, the chronic perpetuation of some vital functions, where the crisis arises about continuing the alimentary or intravenous provision of fluids or nutrients. One argument that sometimes surfaces in this situation may be stated: "The Bible says 'choose life' and that means I (we) should not omit anything that would continue life." Because of the enormous influence of the Bible in shaping this nation's culture and behavior, its rules cannot be taken lightly. Its instructions often seem absolutist, not allowing much room, for instance, for quality-of-life arguments. The famous Nancy Cruzan case is an example in which the biblical injunction was important in buttressing the attitudes of pro-life advocates who opposed removal of her gastrostomy tube.

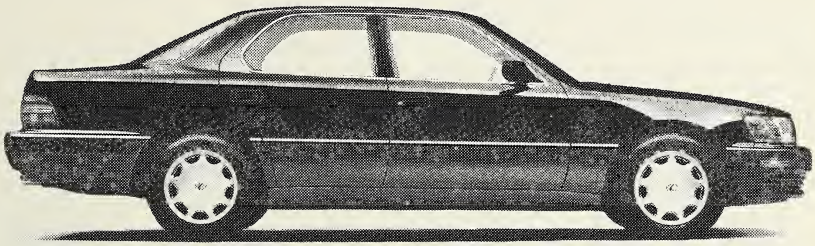
Because of the multiplicity of translations and interpretations of its stories and metaphors, the Bible, so absolutist on the one hand, can seem simultaneously vague and contradictory. The hunt for the "real" meaning of "choose life" took me to several translations of the Bible (Deuteronomy 30:19). The King James translation says "I have set before you life and death, blessing and cursing: therefore choose life that both thou and thy seed may live." But the modification added by verse 20 seems crucial. Its form in the 1962 translation of the Jewish Publication Society says "choose life—if you and your offspring would live—(20) by loving the Lord your God, heeding His commands and holding fast to Him." The King James version of verse 20 adds: "that thou mayest love the Lord thy God, and that thou mayest obey His voice, and that thou mayest cleave unto Him: for He is thy life, and the length of thy days."

Crucial to me about the word "Therefore" and verse 20 is the sense of the *purpose* for choosing life, and—if one is to love the Lord, hearken to His voice and cleave unto Him—the necessity in the sick one of *consciousness* and *meaning*. If they are lost and there is no hope for their return, then choosing life *in order to follow God's commandments* (which is what the passage says to me) is not possible and the argument that appeals to that command correspondingly loses its force. If one judges the passage to be directed not to the patient but to the family and caregivers, the dilemma remains, because loving God and heeding God's commands are not always operationally clear in the modern world of high-tech medicine.

I grant any reader full right to a varying or contrary opinion about the passage in question. Certainly I lay no claim to expertise in biblical exegesis. Other arguments can be made, both biblical and secular. More than searching for "The Truth" in that passage, my purpose is to offer another illustration of how protean is medical practice and to emphasize how crucial is that component called "The Art," which depends mightily on diverse educational backgrounds and modes of thought. Medical science provides much information that is needed for medical practice, but that is only one component leading to the wisdom we need to best serve our patients.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

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The evolution of hospital ethics committees

Robert Weir, Ph.D.

HOSPITAL ADMINSTRATIONS traditionally take three approaches to development of hospital ethics committees (HEC). Some hospital administrations, especially those in community hospitals, have chosen not to establish these multidisciplinary committees because the committees are viewed as problematic. Several reasons are sometimes given: an HEC could be a "loose cannon" that might propose policies unwanted by the administration or it could be a threat to the autonomy and decision-making authority of individual physicians or it might be an additional committee for a medical and nursing staff that is already overworked.

Another approach has been taken by hospital administrators who have established HECs for the wrong reasons, primarily reasons pertaining to public relations aimed at patients, families and the local community. As a consequence, some hospitals have a "ghost" HEC (an ethics committee that never meets). Other hospitals have an HEC that meets but does not have much power, most commonly because the committee functions merely as an administrative ethical rubber stamp. Still other hospitals have an HEC that meets on an irregular basis and accomplishes little, largely because the members of the committee were not carefully chosen and do not have the insight, respect of colleagues and cooperative spirit that contribute to an effective HEC.

The third administrative approach to HECs is represented by many of the nation's largest and best hospitals, including virtually all of the nation's teaching hospitals. In these hospitals, HECs have three important functions: carrying out educational activities regarding biomedical ethics, drafting and proposing relevant institutional policies and consulting on problematic cases. Given these ongoing functions, an effective HEC tends to attract interested, energetic physicians, nurses and other health professionals who want to be where the action is in terms of committee work. In fact, some teaching hospitals have multiple ethics committees: an HEC for the institution, plus more specialized ethics committees in some of the specialized clinical services that regularly face difficult and sometimes unprecedented ethical problems.

Given the impact effective HECs can have on a hospital, the best HECs are characterized by a talented, committed and diverse membership. Of course the size of any HEC depends on the size of the hospital, the availability of physicians and other health professionals and the kind of pool that exists for qualified members other than physicians and nurses. An HEC in a teaching hospital represents the optimal number of qualified members, with a typical HEC in such a hospital having 3-4 physicians as members, plus 1-2 nurses, a social worker, a chaplain, a patient representative, an ethicist, a hospital administrator and 1-2 community representatives.

In the 1990s, HECs are evolving in a couple of ways. First, a recent survey indicates most of the responding HECs are busier than ever. They are handling more case reviews (increasingly in connection with an ethics consultation service) and they are working to make the implementation of the federal Patient Self-Determination Act more effective in their institutions. Second, HECs in several states (including Minnesota and Wisconsin) and regions are establishing ethics committee networks, thereby sharing some resources, addressing problems common to HECs, and working together on statewide projects.

If you think the creation of an ethics committee network in Iowa is a good idea, let me know. I welcome your comments and suggestions.

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.



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John Anderson, M.D.

Those devilish details

THE TASK FORCE HAS gone home and May 3rd has come and gone but we still do not have the President's proposal for health system reform. Reportedly it is 95% finished, except for the details. I am happy to relate that the AMA has been able to get input into their deliberations. The AMA representatives have had several meetings with Ira Magaziner and the task force itself.

In March of this year, Bill Rosenfeld, Hunter Fuerste and I joined 1000 physicians from across the country and went to Washington for the AMA's meeting *Time for a New Partnership.* We heard from both the Democratic and Republican leadership and from Vice President Gore. Their message was sketchy at best. They told us health system reform cannot be achieved without us and chided us to stay involved. The following day we met with Senators Grassley and Harkin and Congressmen Grandy and Nussle. Senator Harkin said Americans should be prepared to pay more, get less and have fewer freedoms than we have now. Congressman Grandy is extremely knowledgable about health system reform and has some very good common sense ideas.

At the AMA's annual meeting in Chicago this June, the hot topic, of course, was health system reform. Many reports and resolutions regarding health system reform were discussed. A forum for health system reform was presented with Senators McKay from Arizona and Wellstone from Minnesota and with Cokie Roberts, an ABC commentator, moderating. The highlight of the meeting, however, was an address by Mrs. Clinton. She gave a masterful speech. It was very rewarding to hear so many of the principles in the proposed plan are also in the AMA's Health Access America.

To repeated applause, Mrs. Clinton promised less paperwork, a revised malpractice system, health insurance reform, freedom for patients to choose their own doctor and freedom for physicians to be in more than one plan. Missing from her speech was information on how to pay for the plan and details on the basic benefit package.

We are still in the first quarter of the health system reform ballgame. The plan will still have to go through both houses of congress, their reconciliation committee then back to the president. There will be ample opportunity for physicians to change the plan if it is not in the best interest of our patients and medicine. After the President signs the plan, it will go to the bureaucrats who will write the rules and regulations. This is a time we will have to be especially diligent. The Devil is usually in the details. It will be essential for every one of us to remain informed and involved throughout the ball game.

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The presentation will be held on the 6th floor of Bergan Mercy Medical Center, 7500 Mercy Road, in Omaha. A 5:30 p.m. social time will be followed by dinner at 6:00 p.m. Dr. Weingarten's presentation will begin at 7:00 p.m. with an opportunity for questions.

Dr. Weingarten's appearance is being sponsored by the Bergan Mercy Wound Care Center, the first and only center of its kind in greater Omaha and supported in part by an educational grant from Curative Technologies, Inc. To make your reservation, please call (402) 398-5500.

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Marion E. Alberts, M.D.

Tuberculosis a resurging problem

DISCONCERTING CONCLUSIONS are presented in an article by Claudia Morain in the June 7, 1993 issue of *American Medical News*. The incidence of tuberculosis in the U.S. increased 20% from 1985 to 1992. This increase was steeper among children with a 2.7% climb in 1992 and a 35% increase since 1985. Lee Reichman, M.D., M.P.H., president of the American Lung Association, calls these data a "colossal embarrassment." There is so much knowledge of the nature of tuberculosis and how to diagnose, prevent and treat this condition. Yet, tuberculosis remains the "largest cause of death from any infectious disease in the world."

Although AIDS patients account for much of the increase in the incidence of tuberculosis in the U.S., other segments of the population contributing to the resurgence are the homeless, the elderly, minorities, immigrants (especially from Asia and Latin America) and prisoners.

In spite of these appalling data, a survey conducted by the U.S. Centers for Disease Control showed that just 50% of physicians could describe a recommended treatment regimen for active tuberculosis. Sixteen percent would use an incorrect regimen for preventive therapy. Two-thirds of physicians cannot interpret a Mantoux test correctly.

Generalists tended to be less astute than specialists in describing a recommended treatment regimen (40% vs. 70%). Older physicians in practice over 25 years were less knowledgeable than physicians in practice seven years or less. This last finding is revealing. Older physicians certainly saw many tuberculosis cases in the past, but with the passage of time seem to have become complacent; that tuberculosis was of less concern as a public health problem. It could be that the younger physicians have been instructed more recently or are more active in CME activities.

Nevertheless, a valid conclusion can be drawn from the CDC survey. Physicians must be educated (or re-educated) about the manifestations of tuberculosis. Raising awareness of its incidence and the necessary diagnostic, preventive and therapeutic skills requires a concerted effort.

An excellent review of the problem appears in a recent issue of *New England Journal of Medicine* (May 20, 1993; pages 1463-65). The medical profession should be aware of this worldwide problem, especially the rising incidence in the U.S. Tuberculosis has been a major health problem for centuries. It must not be overlooked. We must be vigilant to turn the tide of resurging incidence.

Health hucksters continue preying on Iowans

Doctor, do you know what your patients are doing after they leave your office? If you think they are too well educated or sensible to fall victim to health care hucksters, think again.

Christine Clark
IMS staff

WHEN IT COMES TO WEIGHT GAIN, hair loss or more serious health afflictions, hope continues to spring eternal in the human breast. According to the Iowa Attorney General's office, this adage applies to a disappointing number of Iowans.

"Iowans are just too nice and it makes them more vulnerable to health fraud," says Barb White, an investigator for the Attorney General's office. "Health fraud has been a priority in our office for the past six years, but you can only educate to a point."

Victims are embarrassed

White says health fraud is the "least reported area" in the Iowa Attorney General's office because its victims are embarrassed. It's reported even less often than telephone money scams.

"People send in their money in response to an ad which makes some miraculous claim; then, of course, the product doesn't work. They tell themselves it was only $20 and they knew it wouldn't work anyway, so why report it to anyone?" she explains.

This is one reason it's difficult to calculate how much money is spent on quick and easy remedies or cures for everything from cancer to fat. Experts estimate Americans plunk down $28 billion annually for fraudulent cures and treatments.

"Iowans spend millions of dollars on this stuff every year," says White. "No one realizes how many quacks there are victimizing people."

Weight loss is and probably will continue to be the most lucrative area for con artists because everyone wants to believe there is an easy alternative to sensible eating and exercise. White says there will probably always be people vulnerable to weight loss fraud and points to a product called Cal-Ban 3000 as an example. Cal-Ban was marketed as a pill which would allow the user to eat anything but not gain weight. The extremely large pills, which contain 15 mg of guar gum, were actually harmful.

"This was one of the worst cases," White recalls. "One man didn't get a pill all the way down and it expanded in his throat. He nearly choked to death. As a result, Cal-Ban was banned, but not before Iowans bought $200,000 worth of it in one year. This case

Christine Clark is assistant managing editor of *IOWA MEDICINE*.

caused the FDA to reevaluate how they handle weight loss products."

Banning products is difficult

The Attorney General's office works with the FDA to ban products if they are being marketed illegally and makes a special effort if they are proven harmful, White explains. The Attorney General can keep companies from making what White calls "false claims" about what a product can do.

"We are allowed to regulate advertising. In Iowa, a product has to be safe and do what they say it will do," she says. "Usually, if we stop them from making the claims they stop peddling the product here. They know if they can't make miraculous claims, they won't sell anything."

The Attorney General's office concentrates on enforcing laws which protect consumers, even if a company feels its freedom of speech has been violated, White adds.

"Sometimes these two issues conflict, but we're here to enforce the law," she says. "There's a ton of health misinformation out there that we have to deal with."

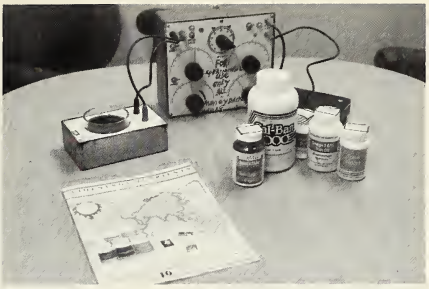
The Attorney General's office has an undercover mailbox where they receive advertisements for various products. Money from a consumer education fund is used to order the products. Money in the fund comes from companies forced to pay fines after running afoul of Iowa law.

Nutritional supplements booming

A fast-growing area of health fraud is nutritional supplements which the sellers claim can do just about anything, including retard the aging process. An example, White relates, is a company called Bioenergy Nutrients. This company sells a product called Coenzyme Q10 which, according to a magazine received in the Attorney General's mailbox, "energizes the entire body at the cellular level by catalyzing cellular energy production."

This sales pitch might sound like so much baloney to legitimate scientists, but it was convincing enough to make Coenzyme Q10 the leading seller for a company which sold $7 million worth of products to Americans last year, White says.

"Nutritional supplements are really a growing market, and they are more difficult for us to deal with," she says. "It's also the center of controversy at the national level. There's a senator from a western state which is the home of one of the big vitamin companies. He says the FDA should have to prove the supplements don't do what they say they do. That's very difficult."



The Attorney General's office has a collection of health care products sold to trusting Iowans.

Preying on the seriously ill

The lowest form of health care con artists are those who target people with cancer and other life-threatening diseases. These charlatans offer hope to people who have lost hope. Seriously ill people—including many Iowans—have been known to clean out their life savings to pay for miracle cures.

"These people are the worst because they know their treatments are worthless," says White. "There was one Iowa man who spent everything in a so-called cancer clinic in Mexico which was run by a chiropractor who had lost his license. As soon as the man's money was gone, the 'doctor' wouldn't treat him anymore. The man eventually died of cancer, but because of him the Iowa Attorney General's office was able to provide information which helped close the clinic."

Other examples can be found closer to home. The Attorney General's office recently brought to court an eastern Iowa man who operated "frequency generator" and "radionics" machines which he claimed could cure everything from heart conditions to cancer. In actuality, the radionics machine does nothing and the frequency generator gives people electric shocks.

"He used only word of mouth advertising. He charged $30 for a consultation and

(Continued next page)

then he charged varying amounts for the actual treatment. He really believed he was helping people, which made him particularly effective," she says. "Then one of his patients had a stroke after one of these 'treatments' so we were able to bring him into court. We got angry calls from some of his other patients who wanted to know why we were persecuting their 'doctor.' I wouldn't be a bit surprised to hear he bought another machine and is practicing again."

Conspiracy theory

Conspiracy theories which appeal to a sense of drama are a reliable tool of the trade for health care con artists. Health fraud artists often sell products by claiming they are being persecuted by the established medical community or have stumbled on a cure that the medical community is trying to keep a secret.

"People sometimes accuse the Attorney General's office of being 'in cahoots' with the FDA or the AMA," White comments.

Health fraud hucksters, she stresses, get "smarter and more clever" all the time. They employ extremely sophisticated advertising techniques. Some consult with lawyers on the best legal tricks to keep the states or FDA away, such as never sending an advertising claim in the same box with the product.

"It's ironic, but if the FDA hasn't banned substances used in certain products, the con artists advertise that the FDA has ruled them 'safe and effective' for use," White reveals. "They're extremely clever."

Some companies offer money-back guarantees that are impossible to collect, but other companies make a point to oversatisfy anyone who complains. This keeps that customer from complaining to a state agency.

What's a doctor to do?

There is no sure defense against health fraud, but White says it is important for physicians to realize it does exist in Iowa and their patients may be vulnerable.

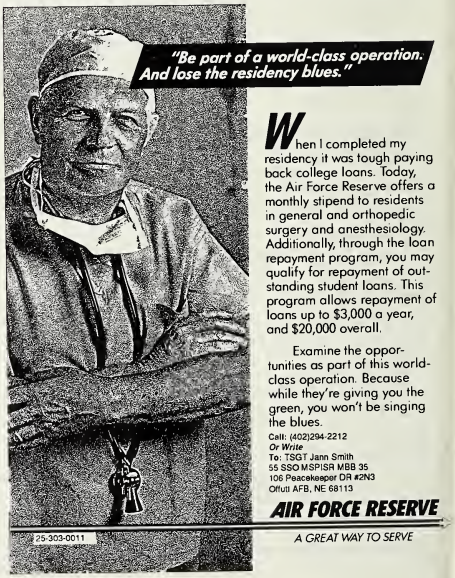
"Whenever we get a call from a citizen about any treatment or product, we always tell them to consult their physician," White reveals. "We also try to caution them about being too trusting, a common trait of Iowans."

Physicians need to be aware that their patients with serious illnesses or patients who have chronic pain are especially vulnerable to health fraud. One California medical school now offers a semester course on health care fraud.

"It's very important for physicians to talk about health fraud with cancer patients and with elderly patients and to report anything suspicious to our office," White concludes. "If the doctor-patient relationship is good and there is open communication, there is a better chance the doctor might become aware of alternative treatments the patient is seeking."

The Federal Trade Commission's Bureau of Consumer Protection has a newsletter which deals with health claims. The newsletter is entitled "Facts for Consumers" and offers common sense advice on how people can separate fact from fiction in the health care arena.

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Are the treatments harmful?

Non-scientifically proven treatments are often benign. Many involve mega doses of vitamins and herbs or other inert products. Probably the most harm comes if the patient withdraws from medically-proven treatment. Most patients who seek non-scientifically proven treatment do not return to their primary physician or oncologist. Some return when they realize the regimen is not going to work, but by then it is usually too late for the physician to be of much help.

Does telling patients the truth about serious or terminal illnesses increase the likelihood they will turn to unusual treatments?

In my experience, most people want the truth so they can deal with it and prepare for the future. If the patient is unaware of the truth, a burden is placed on everyone, including family members and nurses. To most people, being lied to about something this important is the ultimate in disrespect. Quite a few patients suspect something is seriously wrong from the actions of the people around them.

If this issue is dealt with compassionately and if all avenues are explored and explained, it should decrease the likelihood the patient will turn to quackery. Many times, the patient may be content with the physician's recommendations but may get pressure from a concerned family member who had a bad experience with the established medical community and distrusts its members. Some patients try non-scientific methods just to please their loved ones. However, these patients will often continue with the regimens suggested by their primary care physician or oncologist.

Sometimes, physicians are asked by a family member not to disclose the results of a test to a loved one. This places the physician in a very tenuous position, but your prime responsibility and allegiance is to your patient. The patient has a right to know his or her diagnosis. It would be difficult for a patient to trust a physician who had hidden the truth.

If a physician suspects a patient has fallen into the clutches of a health care con artist, should that physician try to intervene?

Once a patient has gone so far as seeking non-scientific treatment, voicing your opinion of the treatment may drive the patient even further away. I believe the best option is to explain why you believe the accepted regimen is preferable, stressing that the choice is still the patient's. Always leave the door open by reminding them you will be available, whenever you are needed. Health care con artists can be very believable and, without proof to the contrary, many patients see it as your word against theirs.

Several years ago, when MOPP therapy for Hodgkins was in its infancy, a relative in her early 20s contracted Hodgkins. This woman's husband was very involved in natural treatments and foods. She was definitely in a curable state but her husband and his family encouraged her to pursue alternative treatment because one side effect of chemotherapy was infertility. She went to someone who believed in mega-vitamin treatment and a strict diet. She followed this regimen for several months despite her family's pleas. She continued to deteriorate and finally went into renal failure. At this point she returned to her oncologist but it was too late. She died about three weeks later of Hodgkins which was curable when first diagnosed.

The health care con artist had promised her she would be in her garden by spring and that her ability to have children would be intact. This was her weak point and the thing that kept her going to him in spite of her deteriorating condition.

I am sure there are many other cases and physicians must continue to educate the public about the dangers of non-scientifically proven treatments. Patients must also understand that, although medical care constantly improves, there are still times when a cure is not available.

Your colleagues want to hear from you!

It's important for Iowa physicians to share opinions about current health care issues. If you have a comment regarding something you've read in Iowa Medicine or an issue affecting the practice of medicine in Iowa, don't keep it to yourself. It's very easy to share your thoughts in a letter to the editor.

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Unusual Case

Frederic Ashler, M.D.
Hamburg, Iowa

A 90-YEAR-OLD GENTLEMAN came to the hospital emergency room at Grape Community Hospital complaining of abdominal pain of two days duration.

The onset of abdominal distress over the previous two days became worse over the last 12-16 hours with pain intensifying in the right lower quadrant. Diarrhea began on the evening of the second day and then nausea and vomiting with intense pain in the right lower quadrant and right flank on the third day after admission.

His past history was negative for any problems associated with the present illness. He had a myocardial infarction in the mid 1970s but since that time had maintained a very active retirement with use of minimal medication for bursitis and arthritis, occasional prostatitis and gouty episodes. He had taken aspirin daily and intermittent use of Allopurinal and Indocin.

Findings on admission were of a very healthy 90-year-old male appearing younger than his age. He was walking bent over and holding his abdomen. The abdomen was flat, tender in the right lower quadrant; also right flank pain with severe rebound; very few bowel sounds. Rectal examination revealed severe tenderness pointing to the right lower quadrant; the prostate was normal.

The extremities were normal with mild crepitation of the shoulder and knee joints. The rest of the examination was non-contributory. Laboratory data included WBC 13.7 with segs 72, bands 7, lymphs 15, mono 5, Hb 13.2 and Hmt 37.5. Urine was negative; BUN was 32. Chest x-ray was negative. ECG showed an old inferior infarct.

Our impression was acute appendicitis, possibly ruptured. Hydration fluids and antibiotics (Calforan) was started. At surgery, following stabilization, we found an appendiceal mass that extended into the cecum with perforation of the appendix. Carcinoid of the appendix with perforation was considered. He had walled off quite well and had a fairly large cecum with ileo cecal valve placed some distance from this appendiceal mass.

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We could get above the mass completely and not sacrifice continuity of the ileum and the cecum.

Clamping was accomplished with a T.A. 55 clamp and the mass was excised intact for pathology study. Cultures were taken at the time we entered the peritoneal cavity. The peritoneal cavity was irrigated copiously with saline, penrose drains brought out through stab wounds, 1 gram Chloromycetin introduced into the peritoneal cavity and the wound was closed.

The culture grew out *Clostridium Perfringens* and antibiotic coverage was appropriately used with no post operative complications. His hospitalization totaled eight days.

Pathology studies revealed a mucinous cystadenoma with mucocele and acute diffuse suppartive appendicitis with perforation.

Over many years one sees many situations, some which leave us hurting for our patients and with a feeling of frustration. This case was an exhilarating and rewarding experience for the patient, family and physician. The patient is back to his usual activities and cares for his wife and their home.

Medical imaging exhibit at UI museum

THE UNIVERSITY OF IOWA Hospitals and Clinics Medical Museum in Iowa City is an educational resource focusing on the history of medicine, medical technology, and health care. Temporary exhibitions of photographs, documents, artifacts, videos and "hands-on" activities offer visitors a glimpse into the structure and function of the human body. Exhibits are designed to appeal to all age groups.

The current exhibition, *Trailing the Invisible Light: A Century of Medical Imaging* runs through January 2, 1994. The exhibition explores medical imaging techniques beginning with Roentgen's discovery of the X-ray in 1895 and includes modern techniques such as computed tomography (CT), ultrasound, magnetic resonance imaging (MRI), and positron emission tomography (PET). Images from each of these techniques are displayed and visitors may try their hand at reading X-rays.

(Continued next page)

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Artifacts in the exhibition include the first X-ray apparatus operated in Iowa, early X-ray and fluoroscope units, portable X-ray units from World Wars I and II, X-ray tubes, a shoe-fitting fluoroscope, an electronic textbook (computer) that visitors may use, videos explaining techniques available at the UIHC and numerous interactive exhibits. Featured is an Egyptian mummy on loan from the Field Museum of Natural History, Chicago. X-rays and CT scans of the mummy, performed at the UIHC, along with 3-D reconstructions of the mummy are being displayed as well.

The Medical Museum is open weekdays from 8:00 A.M.-5:00 P.M. and from 1:00-4:00 P.M. on weekends. Take Exit 242 from I-80 and follow the signs to University Hospitals. Located on the 8th floor of the Colloton Pavilion (take elevator D or F), the museum is free of charge and open to the public. For more information, call 319/356-7106.

BME seeks physicians for peer review committees

THE IOWA BOARD OF Medical Examiners is recruiting Iowa physicians to serve on its six peer review committees. Licensed physicians board certified in anesthesiology, emergency room medicine, family practice, obstetrics/gynecology or surgery are strongly urged to apply.

The BME's peer review committees in each specialty area evaluate quality of care cases and report their findings and recommendations to the Board. Committee members are under contract with the state and are granted the same immunity from civil liability accorded to all members of the Board. Peer reviewers receive a nominal payment for their services and compensation for their expenses.

If you are interested in serving as a peer reviewer, send a letter and a copy of your curriculum vitae to: Peer Review Selection Committee, Iowa Board of Medical Examiners, 1209 East Court Avenue, Executive Hills West, Des Moines, Iowa 50319-0180.

For more information, contact Ann Martino, executive director of the Board, at 515/281-5171.

College of Medicine Highlights

THIRTY-ONE PERCENT OF THE CLASS OF 1993 at the College of Medicine has chosen to enter family practice. That matches the highest proportion of a graduating class going into that specialty over the past 20 years. Forty-seven of the 154 students who graduated will enter residency programs in family practice. Another 21% of the class has chosen to go into internal medicine and pediatrics. That brings the number of graduates going into primary care specialties to about 52%.

DR. RICHARD LYNCH has been named interim dean of the college, succeeding **Dr. James Clifton,** who resigned his position effective April 30. Lynch was professor and head of pathology and professor of microbiology. His appointment will remain in effect until a permanent dean is selected. A search committee has been identifying candidates and will begin screening candidates as soon as a Vice President for Health Sciences is named.

DR. FRANCOIS ABBOUD, INTERNAL MEDICINE was named most distinguished medicine department head in the U.S. by the Association of Professors of Medicine. Abboud was presented the Robert H. Williams Distinguished Chair of Medicine award in April at a ceremony in Washington, D.C. The award is based on progress made in the administration of a department of medicine and contributions to education, research and patient care.

THE GENE FOR A JUVENILE FORM OF THE MOST COMMON TYPE OF GLAUCOMA is located on chromosome one, UI researchers found. Spurred by an Illinois man who traced the disease through five generations of his family, **Drs. Edwin Stone and Wallace Alward, ophthalmology,** and **Val Sheffield, pediatrics,** studied 37 members of the family. Nineteen had symptoms of glaucoma. Identifying the genes that cause glaucoma could affect the way the disease is treated, allowing the development of a specific therapy aimed at correcting a molecular defect in the gene, tailored treatments for individual patients, and screening procedures that could direct health care resources to those at greatest risk.

DR. JOHN ECKSTEIN, former dean, has been awarded *Modern Medicine* magazine's Award for Distinguished Achievement for his "four decades as a pioneer in primary cardiovascular research and as a leader in developing the University of Iowa's educational and research facilities."

DR. NANCY ANDREASEN, PSYCHIATRY, received the Distinguished Service Award of the American College of Psychiatrists at its annual meeting in March. One psychiatrist is selected each year to receive the award, given for major national and international contributions to psychiatry. Andreasen also began her duties as the editor of *The American Journal of Psychiatry,* the oldest medical specialty journal in the U.S., having been founded nearly 150 years ago. She is the journal's 11th editor and the first woman to hold the post.

PEOPLE WITH DEPRESSION FOLLOWING A STROKE ARE LIKELY TO DIE EARLIER than stroke patients who don't have depression, according to **Dr. Robert Robinson, psychiatry.** In a group of 103 stroke patients, those diagnosed with depression were three

(Continued next page)

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times more likely to be among the 53% of patients who died within the 10-year follow-up period. The study also found that those with fewer social ties had the highest mortality rate and never-married patients had a higher mortality rate than those who were married.

DRS. ANTONIO AND HANNA DAMASIO, neurology, have been awarded Portugal's highest honor for intellectual achievement, the Pessoa Prize. The award from their native country recognizes their discoveries in brain mapping. They received the prize from Portuguese President Mario Soares at a ceremony in Quelquez Palace and their acceptance speech was nationally televised.

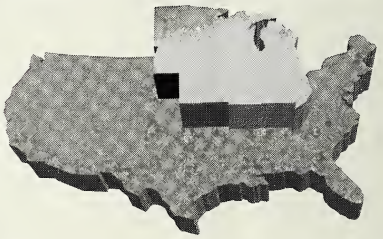
UI COLLEGE OF MEDICINE WILL BE ONE OF 16 VANGUARD CLINICAL CENTERS for a massive 15-year, $625 million Women's Health Initiative. It will be the largest clinical trial ever undertaken in the U.S. and will involve more than 160,000 postmenopausal women ages 50 to 79. According to UI principal investigator **Dr. Robert Wallace, preventive medicine and environmental health,** the study will look at three key areas: the benefits and risks of hormone-replacement therapy; the effects of a low-fat diet in preventing cancer and heart disease; and the effects of calcium and vitamin D supplements in preventing osteoporosis and colon cancer. The UI will receive $11.9 million to conduct its portion of the study, focusing on women in Iowa and western Illinois. **Dr. James Torner, preventive medicine,** is co-investigator. Other UI investigators include **Dr. Susan Johnson, obstetrics and gynecology; Dr. Donald Young, radiology; Linda Snetselaar, Dr. Ellen Gordon** and **Dr. Janet Schlechte, internal medicine; Kristi Ferguson, Office of Consultation and Research in Medical Education** and **Kenneth Mobily, leisure studies.**

THE DIABETES AND ENDOCRINOLOGY RESEARCH CENTER has been funded for an additional five-year period with a $4.5 million grant from the National Institutes of Health. It is one of seven U.S. centers that receive funding for the study of diabetes and hormone action at the cellular and molecular level. **Dr. Robert Bar, internal medicine,** directs the center, which includes 43 investigators from 12 departments at the College.

THE 1992 PHYSICIAN ASSISTANT PROGRAM CLASS RANKED SECOND in the nation on the National Certifying Examination. The 22 UI graduates scored 72 points above the mean score of 524. Half scored above the 80th percentile and two were at the 99th percentile. The UI students were among the 1,531 graduates from 55 PA programs across the country who took the two-day exam. This is the 18th consecutive year that the UI program has ranked among the top 5% of all programs nationally.

FOR PEOPLE WITH EYE DISEASE, TAKING TOO MUCH BLOOD PRESSURE MEDICINE or taking that medicine at bedtime may cause a drop in blood pressure that could lead to sudden blindness or gradual loss of vision, says **Dr. Sohan S. Hayreh, opthalmology.** People who could be adversely affected include those who are taking blood pressure medications and have had previous optic nerve strokes or the 15% to 33% of glaucoma patients who don't have high fluid pressure inside their eyes. Normal reductions in blood pressure pose no threat to healthy peo-

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ple, he notes. To help detect changes in blood pressure during sleep, he used an ambulatory monitor that measures blood pressure over a 24-hour period.

A NEW TECHNIQUE TO EXAMINE THE EYES OF CHILD ABUSE VICTIMS or murdered babies has been developed by **Dr. Robert Folberg, opthalmology,** and could be used to help convict child abusers or clear people who have been wrongly accused of abuse. Deliberate, violent shaking of infants and toddlers can cause bleeding in the vessels of the retina and around the optic nerve. Cataracts or bleeding in front of the eye may mean the child was struck in the face. Doctors need to look for those signs of abuse when examining children who may have been deliberately injured and when doing autopsies, Folberg says. Whenever child abuse is suspected, physicians should take photos of the child's retinas. If the child is brought in again for similar injuries, current eye conditions can be compared with those recorded by the photos.

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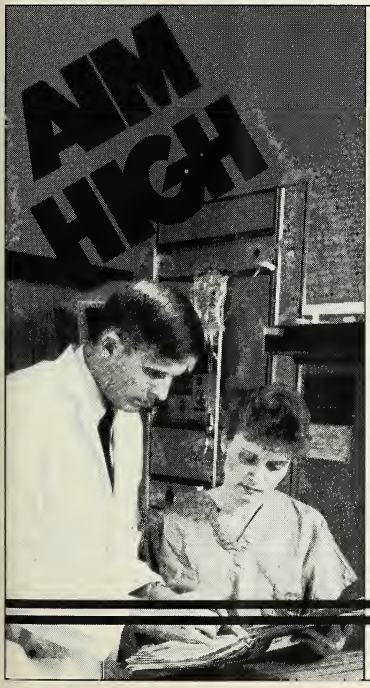
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LEE REICHMAN, M.D. PRESIDENT, AMERICAN LUNG ASSOCIATION NEWARK, NEW JERSEY	**"TUBERCULOSIS: A RENEWED THREAT?"**
JACK SOBEL, M.D. PROFESSOR, IMMUNOLOGY/MICROBIOLOGY WAYNE STATE UNIVERSITY DETROIT, MICHIGAN	**"MANAGEMENT OF THE DEFECTIVE HOST"**
REGINA RABINOVICH, M.D. ASSISTANT DIRECTOR, ALLERGIES/INFECTIONS NATIONAL INSTITUTE OF HEALTH BETHESDA, MARYLAND	**"THE NEWS IN NEW VACCINES!"**
JOHN SEGRETI, M.D. ASSISTANT PROFESSOR, INFECTIOUS DISEASES RUSH MEDICAL COLLEGE CHICAGO, ILLINOIS	**"THE EMERGING PATHOGENS"**
SAM DONTA, M.D. DIRECTOR, INFECTIOUS DISEASES VETERANS ADMINISTRATION MEDICAL CENTER NEWINGTON, CONNECTICUT	**"TICKED ABOUT LYME DISEASE?"**
TIMOTHY TOWNSEND, M.D. ASSOCIATE PROFESSOR OF PEDIATRICS JOHNS HOPKINS SCHOOL OF MEDICINE BALTIMORE, MARYLAND	**"INFECTION RISKS FOR CHILDREN IN THE HOSPITAL"**
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Developments in radiology: techniques new, refined and revisited

In a developing field, optimal diagnostic pathways can change quickly even for unglamorous conditions like deep venous thrombosis. This and two other common clinical problems are reviewed.

Niall Warnock, MB, ChB
Iowa City, Iowa

THE FIELD OF DIAGNOSTIC RADIOLOGY has a propensity for rapid change. Developments in clinical fields often bring new imaging requirements while technological advances can re-write imaging strategies in a very short period. It can be difficult for radiologists to keep up with developments across this broad specialty, so hospital and community based physicians should not hesitate to contact them to discuss appropriate imaging for clinical problems they encounter. Most radiologists welcome the opportunity to participate in selecting investigations. The following examples highlight everyday problems in which the appropriate choice of investigation can speed diagnosis and minimize costs.

Sonography for deep venous thrombosis

Deep venous thrombosis (DVT) is a notoriously difficult clinical diagnosis. Physical examination may be falsely positive in up to 50% of patients and falsely negative with similar frequency. Recently, the radiological diagnosis of this condition has been revolutionized by high resolution sonography. Previously the most widely used confirmatory study was venography, which requires the injection of radiographic contrast via a needle placed in a dorsal foot vein below a very tight tourniquet.

Although the new generation of low osmolar contrast agents has greatly reduced the risk of serious complications from contrast extravasation, venography retains some risk of local and systemic side effects from contrast. It is also uncomfortable, sometimes painful and may fail due to difficulty cannulating small veins in a swollen foot.

Widespread recognition of the usefulness of ultrasound in this field came surprisingly slowly, as the equipment needed has been available for some time. Although the increasing sophistication of doppler blood flow analysis techniques lead to interest in diagnosing DVT, the single most useful sonographic sign does not require doppler technology. The veins are identified with a conventional ultrasound imaging technique and palpated throughout their course via the ultrasound probe. Normal veins collapse when gentle pressure is applied over them and complete obliteration of the venous lumen excludes even partial thrombosis

Dr. Warnock is a visiting assistant professor of radiology with the U. of I. College of Medicine.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR AUGUST 1993

with a high degree of confidence in the femoropopliteal segment.[1]

The theoretical risk that this maneuver might dislodge a clot and precipitate pulmonary embolism has not proved to be a problem in practice, partly because venous thrombus is usually visible as stationary echogenic material within the lumen. Abnormal or absent flow on doppler examination provides ancillary information and may speed the examination but is rarely of critical importance in making the diagnosis. Ultrasound may be a little less sensitive for calf vein thrombosis than for more proximal disease, but results are improving as experience is gained. There is still no general agreement on whether anticoagulation is justified in isolated calf vein thrombosis.

The sonographic venous examination is uncomfortable at worst, but since it requires no preparation or aftercare, ad hoc outpatient referrals are readily examined. The non-invasive nature of the test, the significantly lower cost compared with contrast venography and the unreliability of physical examination make it reasonable to undertake sonography with a relatively low index of suspicion. Identification of DVT will usually lead to hospitalization for initial heparinisation, but a negative study reassures the patient and practitioner and may still identify a cause of symptoms such as ruptured Baker's cyst or superficial thrombophlebitis.

Endovaginal sonography and ectopic pregnancy

Pelvic pain in a woman of childbearing age has diverse causes, many benign and self limiting. When a urine pregnancy test is positive, ectopic pregnancy demands consideration even if symptoms are minor. Timely exclusion of this potentially catastrophic condition may permit an expectant approach to management and obviate the need for emergency room or urgent obstetric assessment. This can often be accomplished sonographically by identification of an intrauterine gestation. The chances of a coexistant ectopic are then very low—around 1:30,000 in women without risk factors.[2] For women at increased risk of ectopic pregnancy (such as those with a history of pelvic inflammatory disease or tubal surgery) the likelihood an ectopic coexists with the intrauterine pregnancy (IUP) is greater, with estimates ranging between 1:8000 and 1:2600, but these are still very favorable odds.

Endovaginal sonography in which a specially designed transducer is positioned adjacent to the cervix has reduced the gestational age at which an intrauterine pregnancy can always be diagnosed from around 6.5 to around 5.5 menstrual weeks, though frequently it can be seen even earlier. There is only a 7-10 day window after a menstrual period is missed before IUP can be confirmed. The improvement is simply because the endovaginal ultrasound probe is nearer the uterus than the conventional transabdominal transducer, permitting use of a higher ultrasound frequency that can resolve smaller embryonic structures. A 1-2mm yolk sac is the first such structure seen.

Because of the variablity of the menstrual cycle, gestational age is better estimated from the size of the surrounding gestational sac rather than the date of the last menstrual period. In the absence of a yolk sac, the most likely possibility is still a normal IUP that is too early to be seen. Failed IUP and ectopic pregnancy are also possible.

Although ectopic pregnancies can often be visualized sonographically, even transvaginal study is negative in up to a quarter of proven cases.[3] Obstetric consultation is therefore desirable for pregnant patients in whom IUP cannot be confirmed at sonography, their management depending on the clinical findings and serial quantitative estimations of serum β-human Chorionic Gonadotrophin (β-hCG).

Many women who have undergone both conventional and endovaginal sonography of the pelvis prefer the latter because it is performed with the bladder empty rather than uncomfortably full. Viability of the pregnancy and the cause of symptoms may remain in doubt after a sonogram showing early IUP. However, concern for sudden maternal deterioration due to ruptured ectopic pregancy is almost eliminated by sonographic demonstration of an intrauterine gestation.

Screening for colorectal polyps

After a period of static or declining popularity due to the proliferation of colonoscopies, the humble barium enema may now be approaching a renaissance. This is not due to technical innovation, the double contrast study having been almost universally adopted for some years now. Rather, the impetus is renewed interest in cost effective investigation, particularly screening for polyps in an effort to reduce deaths from colorectal cancer.[4]

The potential benefits of any screening technique must outweigh the risks, and to be widely implemented it also must be cost effective. For individuals at high risk (family history of colorectal carcinoma or personal history of a previous carcinoma or polyp) regular surveillance is certainly justified, but these issues have not yet been resolved for the public at large. Screening strategies are however recommended by bodies such as the American College of Physicians and various combinations of four investigations continue to be studied.[5]

Fecal occult blood testing has been widely used. It is inexpensive but detects only 30–40% of cancers and has a very high rate of false positives. Sigmoidoscopy enables immediate removal of any polyps, but will miss proximal lesions (40% of colorectal malignancies arise in the ascending and transverse colon) and around 15% of sigmoid neoplasms. Fibreoptic colonoscopy potentially offers examination (and polypectomy or biopsy) of the whole large bowel but fails to reach the cecum in 10-15% of cases and, like sigmoidoscopy, may overlook neoplasms. Complications are a significant concern in colonoscopy, perforation occuring in 0.1 to 0.2% of examinations and death occuring with roughly one tenth of this frequency. The cost of colonsocopy is around three times the charge for a barium enema which has a similar accuracy in the detection of polyps 1 cm or greater and is rarely incomplete or attended by serious complications.

'The potential benefits of any screening technique must outweigh the risks, and to be widely implemented it also must be cost effective.'

These advantages outweigh the priniciple drawback of barium enema which is that in the minority of cases in which such a polyp is detected, sigmoidoscopy or colonoscopy is needed to remove it. Colonoscopy is more sensitive than barium enema in detection of smaller polyps, but the benefits of detecting and removing lesions less than 1 cm in diameter are dubious. The majority of polyps of this size are hamartomatous and do not have malignant potential. Some are adenomas with the possibility of adenoma/carcinoma conversion. Around 1% are malignant, but growth is slow so polyps are likely to be premalignant or curable when detected at a larger size on a subsequent round of screening. A typical screening interval for endoscopy or barium enema is 3 to 5 years, though there is speculation that a single examination at age 60, with polypectomy if appropriate, could be a cost effective screening program for the general population.

Endoscopy and barium studies will continue to coexist and the screening debate is far from over. However, many of the points considered above are also applicable to other colonic pathologies and to the investigation of symptomatic patients. While the impetus for renewed interest in the barium enema is economics, a more general swing back to this long established study may occur.

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Involvement in the CCP Pilot

THE HEALTH CARE FINANCING ADMINISTRATION (HCFA) is committed to restructuring the direction of the Medicare Peer Review Organization program. Its most far-reaching changes will result from the Health Care Quality Improvement Intitiative (HCQII).

HCQII

HCQII is the first structured attempt to use statistical methods to analyze patterns of utilization and outcome and to use clinical practice guidelines as the basis for peer review. Under HCQII, the IFMC will no longer focus on a punitive inspection of utilization and quality. Instead, the review program will support physicians and hospitals in a continuous process of quality improvement.

The HCQII will capitalize on quality improvement through statistical analysis of patterns of performance. Rather than focus on individual cases, the IFMC will study processes of care and outcomes. Feedback based on outcome studies, case reviews and algorithms (decision trees which will help PROs uniformly gather data) will be made available to hospitals and their medical staffs to identify areas for quality improvement. The IFMC will then work with providers to identify problems and develop improvement plans to correct them. Improvement plans are intended to improve outcomes.

CCP

The Cooperative Cardiovascular Project (CCP) is a HCFA special project designed to help build a data base from which to impact processes of care and outcomes.

As part of the CCP pilot project, the IFMC is to work with a committee of physicians, hospital representatives and representatives of other organizations to analyze and disseminate the data. Algorithms will be used to create a profile of the processes of care for three cardiac procedures/conditions: acute myocardial infarction (AMI), coronary artery bypass graft (CABG) and percutaneous transluminal coronary angioplasty (PTCA). Acute myocardial infarction is the first condition on which the IFMC is focusing.

The CCP will determine whether the care provided in individual hospitals is consistent with nationally developed practice guidelines representing a clinical consensus on "best practices." (The AMI algorithms are based on the "Guidelines for the Early Management of Patients with Acute Myocardial Infarction" printed in the *Journal of the American College of Cardiology*, Volume 16, Number 2, with input from other organizations: ACP, ASIM, AAFP, AMA, etc.)

Clinical coordinators

The IFMC's prinicipal clinical coordinator is Timothy Kresowik, M.D., U. of I. College of Medicine Department of Surgery. The two associate clinical coordinators are Andrea McGuire, M.D., Des Moines and Anton Piskac, M.D., Omaha. Within the next six months, these coordinators will oversee the following:

- Formation of study groups covering AMI, CABG and PTCA. The study groups will be responsible for reviewing the data and algorithms and making recommendations for data dissemination to physicians and hospitals.
- Dissemination of preliminary data about AMI and
- Discuss AMI data with individual hospitals.

The IFMC's role in the future of peer review is growing. If you aren't a member, consider joining. If you are a member, involve youself in peer review. It's a dynamic time in the field of health care; be a part of the change.

This article was written by Rebecca Hemann, IFMC vice president of government review services.

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Take a hard look at the ads

Richard M. Caplan, M.D.

I'M NOT MUCH OF A CONSUMER of advertisements. If everyone would deal with them as I tend to, the world of advertising, whether print, radio or television, would be in deep trouble. But once in a while I let them "get to me" and actively attend to their construction and the techniques of selling they illustrate. Maybe that's a partial residue from two courses I took as an undergraduate college student: *Propaganda Analysis* and *Psychology of Advertising*.

Effective education should make us critical in our professional roles and in the ordinary affairs of life—identifiers and critics of falsity, including such variants as innuendo, distortion, hyperbole, unfounded supposition. Growing somewhat cynical may be a necessary price to pay for developing a mind that's free to inquire, criticize and not be bound without justification to the dogma of persons or groups. The evolution and propagation of dogma happens in the worlds of religion and politics, certainly, but also in the world of science and its applied offshoots such as medicine.

With his usual eloquence, Lewis Thomas has said, "Part of the intellectual equipment of an educated person . . . ought to be a feel for the queerness of nature, the inexplicable things." Part of what I find inexplicable in (human) nature is our propensity to be beguiled by assertions. Recently I used the fine services of Iowa's State Historical Society to seek the obituary of a man who died of leprosy in Nevada, Iowa in 1883. I was delighted to find what I sought (even I can master the intricacies of a microfilm reader). But a bonus of added delight was to read the advertisements in those newspapers of 110 years ago. The numbers of ads pushing medicinal products of all types and the "quaint" methods (by standards of my modern sophistication) of wording, drawing and using testimonials sometimes made me laugh out loud, as did this item in the list of practicing physicians: "E.S. Hoag—magnetic healer, will treat without medicine, all chronic ailments, nervous diseases, cancers, ulcers and fever sores. Satisfaction guaranteed."

But today, sequestered in my up-to-date office, I look at some ads that have arrived in my mail and others printed in prestigious journals, and again laugh out loud, although with a bit of head-shaking sadness at the clear implications and evidences of basic human gullibility. P.T. Barnum was right, even when his sucker-born-every-minute comment is applied to the narrow, highly-educated world of medical folks. And even though courses in statistics are present in medical school curricula and journal clubs are commonplace throughout the lifelong spectrum of medical education, we remain variously susceptible to the blandishments of spurious reasoning and clever advertising.

Today's classified advertisements provide their own species of interest and reflect another aspect of our changing medical world. I refer to the many ads designed to attract physicians to "managed-care organizations," to the use of *locum tenens* placement services and to "re-tooling"—educational opportunities to prepare a practitioner to change career into managerial roles of diverse new sorts. Whether one cites the dictum of ancient Heraclitus or the lyrics of Bob Dylan, the times certainly are changing. And let the reader, listener, viewer beware.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

Remediation through personalized CME (Part II)

Richard Nelson, M.D.

DEFICIENCIES IN THE PRACTICE of medicine may be remediable. Prior to the development of a remediation strategy, several issues must be considered.

1. The *specific nature of the deficiency* must be determined. The practicing physician's pattern of medical management should be evaluated by peers who conclude the management does not meet community standards and may compromise the health or well-being of patients. The deficiency may be relatively specific, such as inappropriate management of fluid or electrolyte imbalance, or more extensive in scope, as in the inadequate evaluation and treatment of hypertension.

Broad deficiencies in medical management involving the care of diverse conditions originating in multiple organ systems are sometimes identified in physician practice. These situations may not be amenable to focused remediation due to the physician's basic lack of fundamental knowledge. In such cases a full residency program may be necessary to establish practice competency.

2. The physician must not have a *cognitive disability* that compromises learning or judgement. Neurological disorders associated with aging, stroke, alcoholism, substance abuse and other mental conditions may compromise medical practice. The physician may recognize the limitations created by the disorder and voluntarily restrict his or her practice or retire if the condition is permanent or progressive.

In other situations, especially in the early stages of certain disorders, the impairment may not be obvious to the affected physician or the physician may deny the development of symptoms. Physicians are accustomed to coping with adversity and may adjust when confronted with a threat to their function without acknowledging their difficulties to themselves or colleagues. If clinical management skills are recognized to be deficient by colleagues and not by the individual, determination of the severity of the deficiency will be exceedingly difficult. Remediation may be impossible.

3. The physician must *agree there is a need for remediation.* Denial of the documented deficiency, even in the absence of cognitive disability, will preclude successful remediation. The peer review process will likely provoke a disagreeable response in many physicians when their practice skills are challenged. They may conclude they have been unfairly evaluated, that the specific cases reviewed were not representative of their management skills or even that other motives are at work in the peer review process. Threatened with the loss of hospital privileges or an action restricting a medical license, the physician may agree to remediation but remain emotionally and intellectually resistant. Prior to remediation, the physician's understanding of the need for remediation and active cooperation must be assured.

Assuming a deficiency can be specified and the physician is able and willing to participate in a learning process, a remediation plan can be developed. The design of that plan necessitates the active involvement of the physician with an educational team.

Academic medical centers have not historically developed the capacity to provide remediation. Most centers offer the opportunity for physicians to participate in a personalized CME experience. However, these experiences are structured as a learning opportunity for the physician who has no demonstrated deficiency and is motivated by an interest in acquiring new knowledge or skills. Remediation for deficiencies is an altogether different task.

In Part III, practical options for remediation through personalized CME will be described.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

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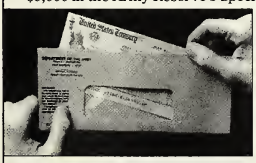
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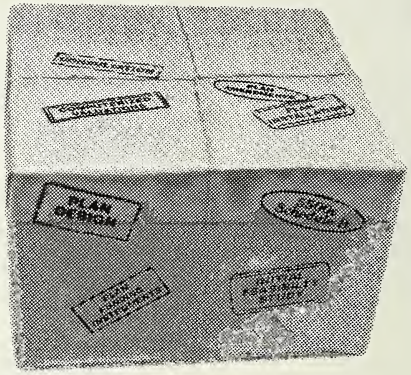
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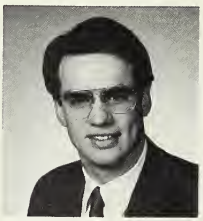
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John Anderson, M.D.

What is IMS Services?

This month, the IMS and IMS Services are losing a tremendous asset, namely Don Neumann. Don is retiring after 28 years of service to our two organizations. What a tremendous job he has done. For the past eight years he has managed IMS Services and has been very innovative in developing new programs and expanding existing programs. Recently, he helped guide IPMIT through a merger with Midwest Medical Insurance Company (MMIC).

Just what is IMS Services? It is an independent, for-profit corporation which has only one stockholder, the IMS. IMS Services is a multifaceted company serving many needs of Iowa physicians. More importantly the profits help reduce our IMS dues. Thus this corporation with assets over $1 million is very vital to the IMS.

With the IPMIT—MMIC merger, the two companies will have assets of over $200 million. This will give Iowa physicians even more security. IMS Services will continue to perform an agency function for MMIC.

One of the most popular IMS Services programs has been the Statewide Physicians Health Insurance Program. This has been operated through the offices of Lowe and Associates in conjunction with Blue Cross/Blue Shield of Iowa.

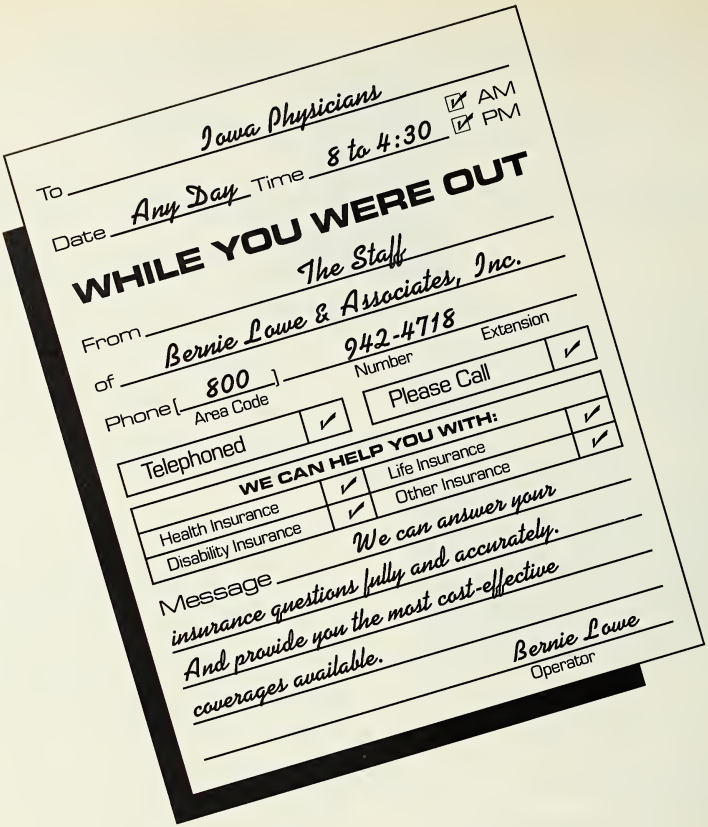
IMS Services Workers Compensation Program is also widely used. This program is run in cooperation with Farm Bureau of Iowa and provides Iowa physicians with a low cost workers comp program.

Other programs provided by IMS Services include the Accounts Receivable Management Services (ARMS). This growing new program offers electronic claims transmission to insurance carriers. Another new program is the Hepatitis B Vaccine Program whereby physicians can purchase this vaccine for use in their offices. You can even get a Gold MasterCard through IMS Services or a magazine discount program. Life and disability insurance policies are also available.

IMS Services offers practice management programs which are increasingly popular. Programs have been arranged all over the state on CPT coding, ICD-09 use, E&M coding, AMOS computer programs, the use of RBRVS to establish fee schedules and retirement planning.

IMS Services provides staff support for several of the state specialty societies. This is a very valuable service to the smaller societies which cannot fund full time staff. IMS Services also assists the Iowa Medical Group Management Association (IMGMA), an association of our office managers.

As you can plainly see, IMS Services is a very important arm of our Society and Don has done a masterful job running it. Thank you, Don, from all of the IMS membership.



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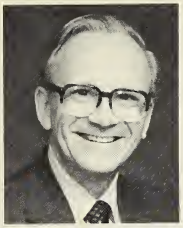
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The Editor Comments



Marion E. Alberts, M.D.

The floods of 1993

At the time of this writing many Iowans are undergoing stressful experiences. Continuing rains have taxed the streams, rivers and reservoirs to limits unknown in our lifetimes. Flood waters have inundated croplands as well as cities. Large sections of residential and business areas have become awash. Numerous persons have faced evacuation from their homes and work places.

In Des Moines the problems were compounded by the loss of the city water filtration and pumping systems. A quarter million people have been without the water supply they usually take for granted. Water has been imported from all over the U.S. for drinking and sanitation. The nearby water systems have been called upon to assist in providing water for Des Moines citizens.

The outpouring of supplies and volunteer assistance has been heart-warming. In the face of disaster, thousands of people have labored long hours building and rebuilding levees to hold back the onslaught of the raging rivers. There has been a camaraderie that defies the imagination. It has become very obvious that Iowans in dire straits can pull together for the common cause of survival.

Yet, there is the human nature element which is disturbing. Already there are derogatory remarks being made placing blame on this or that body for various failures. Was there adequate warning? Why were reservoirs not fulfilling their intended purpose of preventing massive floods? Let us hope that after all settles down the unfounded criticism of the disaster management in Iowa and other states will cease.

Medical implications of flood disasters can be far-reaching. There remains the task of disease control and provision of hygienic environmental projects to avoid outbreaks of enteric infections, tetanus and mosquito borne diseases. The hospitals, clinics and physicians' offices so far have faced challenges because of lack of city water. Some services by the medical profession have had to be curtailed. Many elective procedures have been delayed. The actions by the health authorities in disease prevention have been admirable. The public has been adequately instructed through the media regarding public and personal health measures. More will need to be done and I know it will be done in a laudable fashion.

Disaster is rewarding in one way. It brings us together to master the problems at hand and enables us to move forward to start life anew, armed with knowledge that may prevent future similar mishaps.

Cast aside blame, innuendos and political banter. The hurdles can be overcome. So far Iowans have demonstrated they have what it takes to overcome adversity. The medical profession salutes each and every Iowan awash in the disastrous floods which have inundated their lives.

After the flood: the dripping faucet syndrome

In a recent television interview, a woman who lost her home in the floods summed it up very well. "Me and all my neighbors, we just shake all the time," she said. This article discusses the possible psychological effects of the Great Floods of '93.

Loren Olson, M.D.
Des Moines, Iowa

LOSS, THE COMMON DENOMINATOR of all disasters, plays an etiologic role in many psychiatric disorders. Disasters of the magnitude Iowans have experienced due to recent flooding can easily overwhelm the psyche, but the degree to which psychiatric disorders are the result is not well established. Some sociologists believe the consequences of a disaster are simply a normal human response to tragedy and psychometric test data have not been standardized on disaster populations.

McFarlane described four psychological stages of a disaster.[1] The initial phase (Table 1) is characterized by a spirit of cooperation, high energy, heroism and emotional states of numbing and denial as victims do not yet perceive the impending long-term effects of property loss and personal upheaval. Symptoms do not usually appear until a few weeks after a disaster; people who then present with psychiatric difficulties often have had a low degree of exposure but a high degree of pre-existing psychological vulnerability.

Freud postulated a "stimulus barrier" that regulates perceptual entry into the psychic apparatus.[2] This protective mechanism is enhanced by social supports. In the early phases of disaster, intrusions are warded off by a blunting of affect and a constriction of thinking. Gradually, as the psyche feels safe, emotional threats are sampled and the barrier is removed.



This gymnasium in a West Des Moines grade school was filled to capacity with residents forced from their homes by flood waters.

Trauma intrudes

The second phase is characterized by immediate and personal experience with the disaster such as cleaning up homes and businesses and assessing major property losses. The loss due to any casualties begins to sink in for the survivors. Trauma intrudes into the thought

Dr. Olson is medical director and founder of Central Iowa Psychiatry and medical director of psychiatry for Iowa Methodist Medical Center.

patterns and emotions are characterized by disturbed affects and hyper-arousal.

During the third stage, victims who have experienced prolonged, high degrees of exposure to the effects of the disaster begin developing symptoms. Progressive emotional constriction makes these people vulnerable to further victimization by unscrupulous individuals who prey on disaster victims. Patients with symptoms attributable to the flood will appear long after the waters recede. Even normal grieving may last one to three years. Many will minimize their distress through the prolonged work of the recovery process.

The final stage is the delayed onset of anxiety and depression. This is often precipitated by a prepotent experience which reawakens the original disaster, for example, a movie which involves scenes of flooding. During this phase, however, the majority will be preceding to resolution and healing.

Disaster victims include persons with levels of adjustment ranging from normal to high risk in proportion to the population at large. It should not be assumed the development of symptoms following a disaster signals a more impaired member of the population. Pre-morbid and co-existing conditions such as anxiety disorders, alcohol and drug abuse, depression and organic brain symdrome must be distinguished from the emotional consequences of disaster.

Children, elderly especially vulnerable

The experience of the disaster is high risk to children and the elderly and to those bereaved or with heavy losses (Table 2). The impact of lost possessions is unrelated to their material value but is determined by the associated memories and experiences. The individual who has lost a $35,000 home may have more emotional and relatively more financial investment than an individual who has $500,000 in property damages.

During the months preceding the flood, and likely for several months after, Iowans have experienced a kind of "dripping faucet stress." These stresses individually are of seemingly minor consequence, but when taken collectively, can push one to the edge. Living in cramped quarters and dealing with bureaucracy and cash flow uncertainties for farms and small businesses can create a constant strain for flood victims. Those less directly affected have felt such pressures as extended cloudy days, getting water for families, working in uncooled environments, detours and the threat of increased taxes. This distress is apt to cause disrupted interpersonal functioning such as irritability, withdrawal or loss of pleasure in shared activities.

TABLE 1

PSYCHOLOGICAL RESPONSES TO DISASTER

Stage 1	1–7 weeks	Diverse disorders: A. High energy/heroism B. Numbing/denial C. Exacerbation of pre-existing psychopathology
Stage 2	8–18 weeks	Disturbed affects and hyper-arousal
Stage 3	19–58 weeks	Emotional constriction
Stage 4	Delayed onset	Post traumatic stress disorder

(Adapted from McFarlane, 1986)

TABLE 2

FACTORS CREATING INCREASED VULNERABILITY TO EMOTIONAL SEQUELAE OF DISASTER

1. Emotional investment in what is lost
 A. Casualties
 B. Property
 C. Physical injury with loss of function
2. Degree of exposure to the disaster
3. Entrapment for extended periods
4. The type of disaster (natural vs man-made)
5. Anticipation time prior to onset
6. Duration of the event
7. Individual factors
 A. Constitutional
 B. Family support
 C. Previous or intercurrent life events
 D. Pre-existing psychopathology
 E. Youth/old age
 F. Sociocultural factors

The universal reaction to life-threatening events includes the autonomic phenomenon of tremulousness, tachycardia and palpitations and psychological reactions of bewilderment and confusion.[3] Children's symptoms include anxiety, insomnia, phobias, play or talk that focuses on the event, loss of interest in school, difficulty concentrating, encopresis and enuresis, aggressive behavior and nausea and vomiting.[4] Those not directly affected by the disaster may experience "survivor guilt." This occurs when one survives in a situation where others did not or one experiences guilt concerning the things he/she has done in order to survive.

(Continued next page)

Symptoms which are delayed are sometimes attributed to factors other than the disaster. Sociologists who say there is no increase in psychiatric diagnosis may have overlooked somatization disorders, conduct disorders and post traumatic stress disorders.

Post traumatic stress disorder

Since the Viet Nam era the diagnosis of post traumatic stress disorder (PTSD) has been fairly common for any experience which produces intense fear and a sense of helplessness.[5] The characteristic symptoms of PTSD develop following a psychologically stressful event that is outside the range of usual human experience.[6]

Characteristic symptoms include reexperiencing the traumatic event, avoiding stimuli associated with the event and an increased state of arousal. PTSD seems to be more severe and longer lasting when the trauma is of human design rather than "an act of God." There is also an association between the severity of PTSD and the adequacy of social support systems. Initial symptoms of acute PTSD often include sleep disturbance and nightmares. Chronic PTSD is usually characterized by constricted affect, numbing, disturbed memory and concentration. People with PTSD will go to great lengths to avoid anxiety and intrusive thoughts. They may experience a pervasive avoidance of any stimulus which may trigger their symptoms. Other symptoms of chronic PTSD often include physical or psychosomatic disorders such as headaches, body aches and hyperventilation.

In one study of disaster victims, all individuals who sought treatment were seen initially by a family practitioner. Few received a psychiatric referral.[1] The levels of detection of PTSD by primary care physicians was low. However, the diagnosis was also missed by experienced psychiatrists.

Because of the large number of people affected early in a natural disaster like a flood, mental health workers can participate best as consultative and facilitative health care providers since clinical personnel needed for a large scale therapy will not be available. Most of the work related to mental health must be accomplished through the collaboration of the mental health community with the leaders from service clubs, business, the clergy, the school, health care providers and other local constituencies.



Thousands of people received free tetanus shots as a precaution against contaminated water.

Crisis intervention is support through protection and consolidation. The basic concepts of crisis intervention follow the "Iron Rule," i.e., do not do for anyone what they can do for themselves. The coping skills of the normal person are temporarily overwhelmed; rapid and specific help from others can restore the person to the pre-crisis level of functioning. However, only functions the person cannot handle should be handled by others and the help offered must be congruent with the coping style of the person. Help should be discontinued as quickly as possible in order to enhance the victim's self-esteem.

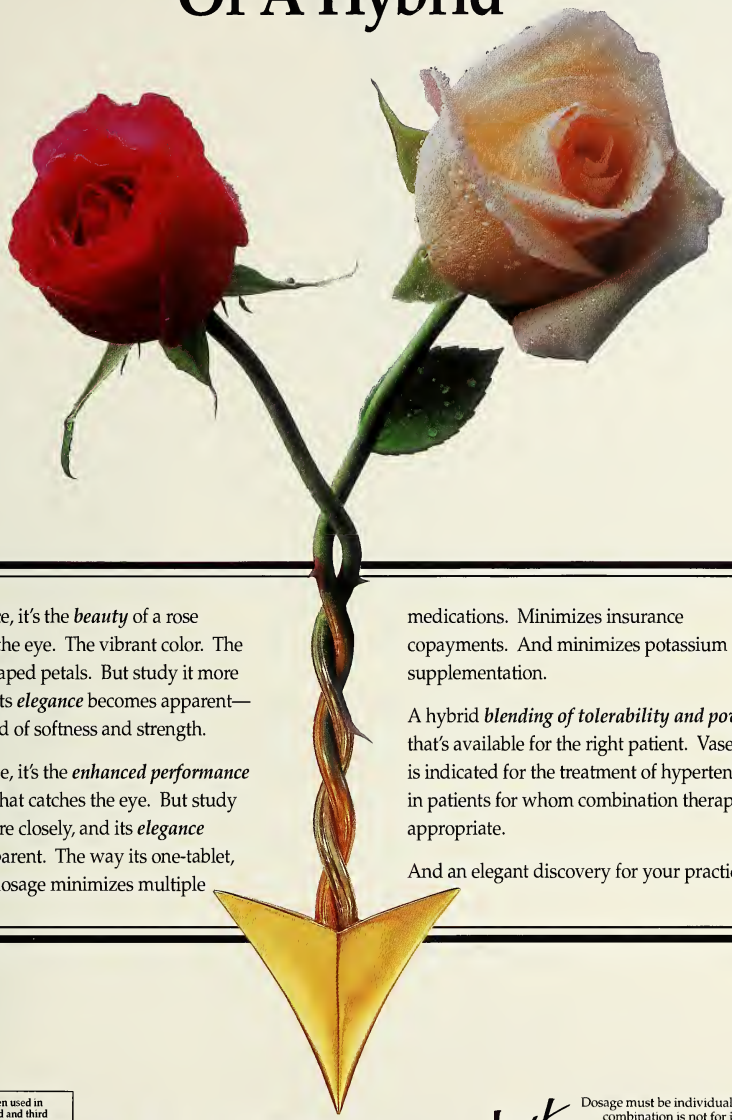
Help from different sources

Treatment will only be as good as case detection. Physicians must have a high degree of suspicion in the months and years to come in order to identify the connection between emotional and physical symptoms and this disaster. The most frequent diagnostic distinction will be between adjustment disorders, bereavement, brief psychosis and PTSD. A knowledge of how an individual has mastered earlier conflicts can give one a good indication of how they might respond.

If support is insufficient or if insomnia leads to difficulty coping, anti-anxiety drugs on a single-dose basis or hypnotic on a night-to-night basis may be indicated. For most cases of PTSD, antidepressant medications plus time-unlimited, i.e., not brief, psychotherapy will be required. Tricyclic antidepressants may have some advantages in reducing nightmares and other sleep disturbances.[7]

(Continued next page)

Discover The Elegance Of A Hybrid



At first glance, it's the ***beauty*** of a rose that catches the eye. The vibrant color. The delicately shaped petals. But study it more closely, and its ***elegance*** becomes apparent—a gentle blend of softness and strength.

At first glance, it's the ***enhanced performance*** of Vaseretic that catches the eye. But study Vaseretic more closely, and its ***elegance*** becomes apparent. The way its one-tablet, once-a-day dosage minimizes multiple medications. Minimizes insurance copayments. And minimizes potassium supplementation.

A hybrid ***blending of tolerability and power*** that's available for the right patient. Vaseretic is indicated for the treatment of hypertension in patients for whom combination therapy is appropriate.

And an elegant discovery for your practice.

USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, Vaseretic® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

VASERETIC® 10-25 *Next*
Enalapril Maleate-Hydrochlorothiazide

Dosage must be individualized; the fixed combination is not for initial therapy.

Evaluation of the hypertensive patient should always include assessment of renal function.

For a Brief Summary of Prescribing Information, see adjacent pages.

TABLETS
VASERETIC®
(ENALAPRIL MALEATE-HYDROCHLOROTHIAZIDE)

10 mg

25 mg



USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC® (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General; Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions;* and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (See ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions, Enalapril Maleate and Hydrochlorothiazide*).

Pregnancy, Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality,* below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of embryonal abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General; Enalapril Maleate; Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent pre-existing renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements, and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril. (See *Drug Interactions.*)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmias and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium*).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients; Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g., sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions; Enalapril Maleate; Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide; When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Cholestyramine and colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively. Thiazides may be administered two to four hours before the resin when the two drugs are used concomitantly.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy, Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other:* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough.*

Clinical Laboratory Test Findings; Serum Electrolytes: See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium, See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.5 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular:* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*); pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven or rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression, a few cases of hemolysis in patients with G-6-PD deficiency have been reported in which a causal relationship to enalapril cannot be excluded; *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, alopecia, flushing, photosensitivity; Special Senses: Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tinnitus.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses:* Transient blurred vision, xanthopsia.

* Based on patient weight of 50 kg.

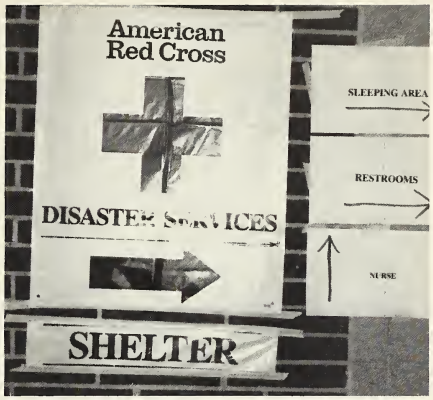
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Temporary shelters for homeless flood victims were set up in many public buildings around Des Moines and West Des Moines.

People who seek psychiatric treatment will in most cases be those who have had formalized psychiatric symptoms and treatment prior to the event. Those who have stress and grief will seek help from kinship or family care providers. Those who may respond to counseling can be identified through outreach programs. Many with anxiety, depressive and psychosomatic disorders will first be seen by their family doctor.

Victims may feel they need emotional help but will not be inclined to it. Patients sometimes blame themselves for their own disorders and victims prefer not to see themselves as mentally ill as they struggle to maintain a sense of self-reliance. Some will experience a sense of shame for not having coped successfully. Many hope things will return to normal when they have recovered their lost property. However, financial losses will limit their ability to pay for services and their interest in doing so.

Midwest tradition

Responses of victims and disaster workers are similar. Mental health agencies must cooperate with agencies providing disaster relief to help workers who show signs of severe fatigue and burnout.

Some believe disasters produce therapeutic effects on social systems by creating social solidarity and breaking down social barriers

(Continued next page)

and economic distinctions. While standing naked in a shower line at Camp Dodge, one cannot help but think that may be true.

The Midwest has a strong tradition of neighbors coming to the aid of neighbors in need. Iowa and its contiguous states have attracted the attention of a concerned and sympathetic world.

At a time when our society is characterized by random violence and the resurrection of social barriers, the Midwestern survivors of this disaster have demonstrated that our society still has a strong measure of mental health. However, we must now prepare to deal with the long-term consequences.

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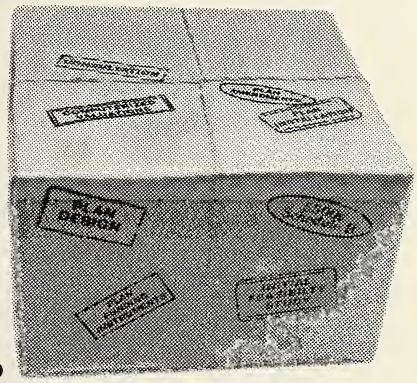
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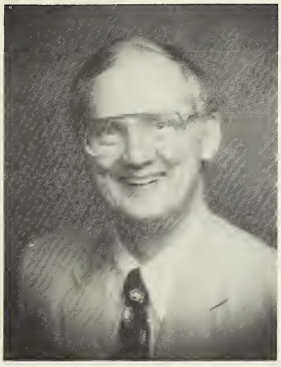
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Fond good-bye to key IMS staff member

AFTER 29 YEARS OF SERVICE as a member of the Iowa Medical Society executive staff and, more recently, IMS Services, Don Neumann has announced his retirement, effective September 3, 1993.

However, until January, he will continue to provide consultative services to the Midwest Medical Insurance Company, which recently merged with Iowa Physicians Mutual Insurance Trust and to the Statewide Physicians Health Insurance Program for IMS members.



Don has served a dual role as assistant executive vice president of the Iowa Medical Society and as general manager of IMS Services, an IMS subsidiary.

He served as managing editor of IOWA MEDICINE for several years during which time the journal won numerous awards for excellence in content and design. He had a leading staff role in the formation, growth and success of Iowa Physicians Mututal Insurance Trust.

In 1989, Don was honored at the IMS Annual Banquet for 25 years of outstanding service.

At that time, it was noted by Society officers that "Don has earned the admiration and friendship of many Iowa physicians, as well as the respect and affection of IMS staff members . . . past and present. His good humor and his gentle ways, along with his knowledge and creative talent, are traits which have endeared him to his office colleagues and to the physicians of Iowa."

Don Neumann is one in a million. He leaves the IMS/IMSS with the high esteem and good wishes of those he has served so well.

Your commitment to God, your family, your work and your community has been exemplary. I wish we could clone you.

John Anderson, M.D., IMS President/1993-94

It's hard to just say "thank you" and have it convey all my feeling for the 29 years of dedication and loyalty you've given to the IMS.

Dennis Walter, M.D., IMS President/1987-88

We will always be grateful that you chose to use your many talents on behalf of the doctors in Iowa.

John Tyrrell, M.D., IMS President/1984-85



DEAN, COLLEGE OF MEDICINE
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The University of Iowa seeks candidates for the position of Dean of the College of Medicine. The Dean reports to the Vice President for Health Sciences, is spokesperson for the faculty of the College, and represents the College in interactions with practitioners throughout the state. Responsibilities of the Dean include faculty recruitment and appointments; educational, clinical and research programs; admission and placement of students; student affairs; fiscal planning and management; short term and strategic planning; space and equipment utilization; and other activities that affect education, research, and professional service within the College.

The College of Medicine is among the top ten public medical schools in National Institutes of Health funding and is part of a major research university. The College is affiliated both with an adjacent, comprehensive Department of Veterans Affairs Medical Center and with the University of Iowa Hospitals and Clinics, the largest university-owned teaching hospital in the United States.

Candidates should possess an M.D., Ph.D., or both, have a distinguished record of teaching, research, and service in a medically-related field and qualify for senior academic rank in the College of Medicine.The successful candidate must have a demonstrated ability to foster an environment in which excellent teaching and scholarship can flourish, as well as an appreciation for the importance of developing and promoting clinical programs in a state which relies heavily on rural, primary care physicians. The candidate should have a demonstrated capacity to cooperate and collaborate successfully within the complex environment of a major research university health science center.

The Search Committee seeks candidates who have a record of innovative and effective administrative leadership; possess strong advocacy skills; expect and enjoy interaction with students; and who have a commitment to increasing diversity among students, staff, and faculty. A demonstrated knowledge of fiscal management within the complex, changing health care field is essential. A record of productive interaction with representatives of business and industry, community, and state leaders, legislators, and officials at all governmental levels is highly desirable.

The Search Committee will accept nominations and applications until the position is filled. The Committee is particularly interested in identifying minority and women candidates. Applications should include a *curriculum vitae* and the names, addresses, and telephone numbers of five references. Please send nominations or applications to:

Richard D.Williams, M.D.
Professor and Head, Department of Urology
Chair, Search Committee for the Dean
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Sherry Bulten, M.D.

Future is good for women physicians

The author, a Humboldt family physician and chairperson of the IMS Committee on Women Physicians, discusses the contribution women can make to organized medicine.

The AMA has designated the month of September as "Women in Medicine" month. Why is this important?

Women in Medicine month is so designated by the AMA to bring attention to the growth and achievements of women physicians/medical students.

IMS records indicate there are 453 women physicians in the state, 312 of whom are members of the IMS. Why do you think it is important that women physicians join the IMS, as well as the AMA?

It is important that women become involved at the grass roots levels in order to contribute their particular perspective to health care development and professional issues. Physician leaders are developed through their activities at the local and state society levels. They can then move on to national leadership positions.

There are 30 women physicians serving on IMS committees. Do you believe family responsibilities influence the number of women members who become active in the Society?

A survey conducted by the IMS Committee on Women Physicians revealed two-thirds of the respondents had children under 18 and half had children under age 10. I do believe family responsibilities have a direct bearing on the amount of time available for many of our women physicians to become active in organized medicine. Those same experiences contribute to shaping the special perspective these women can share.

Is sexism in medicine a myth or is it actually a problem in Iowa?

Women physicians are becoming more widely represented in numbers and leadership roles. However, women physicians are

(Continued next page)

still in a minority position, with many of the attendant problems.

In 1990, the AMA issued a report entitled "Gender Disparities in Clinical Decision-Making" which dealt with societal and medical perceptions affecting women's health. The report concluded that women have been and continue to be disadvantaged because of inadequate attention to the research, diagnosis and treatment of women's health care problems. How are some of the major health problems affecting women being addressed?

There has been much awareness of this issue over the past few months. The Women's Health Institute has been funded by NIH to examine heart disease, cancer, strokes and osteoporosis in some 160,000 women age 50 and over. The AMA's Health Access America has included many proposals pertinent to care for women. Closer to home, the 1993 IMS Scientific Session on Sunday morning concentrated on issues of hormone replacement.

What does the future hold for women physicians?

The future is good. The number of women physicians is growing rapidly and more women moving into leadership roles. Our practice styles are being widely recognized and accepted.

There is much work yet to be done, but the future is good.

Editor's Note

The IMS Committee on Women Physicians calls attention to a special program on "Women in Medicine—Personal Growth and Professional Development" a CME offering of the Mayo Clinic, Rochester, Minnesota. The program provides five credit hours in Category 1 of the AMA Physician's Recognition Award.

The conference will be held in Phillips Hall of the Siebens Medical Education Building in Rochester, September 17-18.

A special get-together will be arranged for Iowa physicians attending the conference.

Specific program information can be obtained by calling the IMS (223-1401 or 1-800/747-3070).

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References:

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For more information about the FIS program or the AMA Investment Advisers, Inc., please write or call IMS SERVICES, 1001 Grand Avenue, West Des Moines, Iowa 50265 — Telephone 515/223-2816 or 800/728-5398.

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New members (as of April 18, 1993)

Lamar Bushnell, M.D., cardiothoracic surgery, Iowa City
Richard Ammar, Jr., M.D., resident, Iowa City
Peter Fries, M.D., ophthalmology, Davenport
Lyle Brown, M.D., cardiothoracic/vascular surgery, Des Moines
Ava Feldman, D.O., dermatology, Des Moines
Bernard Munro, M.D., obstetrics/gynecology, Des Moines
William Stanley, D.O., cardiac/vascular/thoracic surgery, Des Moines
Donald Young, D.O., reproductive endocrinology, West Des Moines
Philip Elizondo, M.D., orthopaedic surgery, Fort Dodge

Deceased members

David Holman, M.D., life member, pathology, Mesa, Arizona
Ronald Meseke, D.O., 45, obstetrics, Bettendorf, died April 29
Paul Leehey, M.D., 88, life member, family practice, Independence, died April 25
Clare Jones, M.D., 87, family practice, Spencer, died December 10
Howard Down, M.D., 91, life member, surgery, Sioux City, died March 10
Robert Isham, M.D., 74, general practice, Osage, died May 5
Roy Patterson, M.D., 91, family practice, Webster City, died January 20
Alson Braley, M.D., 87, life member, ophthalmology, Coralville, died May 29
William Klumper, M.D., 72, radiology, Storm Lake
George Bello, M.D., 47, anesthesiology, Bettendorf, died July 15
John Kelly, M.D., 56, family practice, Spencer, died June 15
Lila Furman, M.D., 60, internal medicine, Ames

Miscellaneous

Gilberto Solivan, M.D., dermatology, recently joined the medical staff of Park Clinic in Mason City.
Basil Rodansky, M.D., family practice, recently joined the medical staff of Park Clinic in Mason City.
Nidal Harb, M.D., Clinton, has been invited to serve on the Government Relations Committee for the American College of Cardiology. Dr. Harb also recently participated in an international study entitled Global Utilization of Streptokinase and TPA for Occluded Arteries Trial (GUSTO) in Amman, Jordan.
N. K. Pandeya, D.O., Des Moines, has been selected as the State Air Surgeon of the International Guard of Iowa.

Items in this column are compiled from IMS membership department records. News from individual physicians, clinics and hospitals is welcomed. Send news items to: "About IMS Members" c/o IOWA MEDICINE, 1001 Grand Avenue, West Des Moines, Iowa 50265.





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CHARLES KALLICK, M.D. CHAIRMAN, INFECTIOUS DISEASES COOK COUNTY HOSPITAL CHICAGO, ILLINOIS	**"INFECTIOUS DISEASE AND OLD AGE"**
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Management of community-acquired pneumonia

Iowa physicians treating pneumonia patients are confronted with many questions. This article discusses accurate diagnosis and effective treatment of this common infectious illness.

Matt Johnson, M.D.
Iowa City, Iowa

PNEUMONIA IS THE SIXTH LEADING cause of death in the U.S. and the fifth leading cause of death in persons 65 years of age and older.[1,2] Community-acquired pneumonia continues to be one of the most common infectious diseases treated by primary care physicians. The spectrum of illness can range from a mild respiratory disease to a life threatening illness with significant mortality.

The physician caring for a patient with pneumonia is confronted with many questions. What is the prognosis for a given patient? What is the most effective way to establish the etiologic agent? What is the best empiric antibiotic treatment?

This article reviews recent literature regarding the management of community-acquired pneumonia.

Cough, fever, chills

The classic presentation of acute community-acquired pneumonia is an acute onset of fever, purulent cough, chest pain, tachypnea, evidence of a new infiltrate on chest x-ray and leukocytosis.[3] In a recent study, the most common clinical manifestations were cough (88%), sputum production (71%), fever (69%), dyspnea (60%), chills (48%) and chest pain (30%).[1] The most common signs were tachycardia (45%) and tachypnea (43%). It is important to remember that pneumonia in an elderly patient can present with relatively non-specific symptoms such as change in mental status or change in appetite. Unfortunately, no constellation of symptoms and signs is specific for any causative organism, so the clinician must rely upon information other than the clinical presentation to establish the etiologic agent.

The atypical pneumonia syndrome has been described in adolescents and younger adults. Usually, the onset of the illness is more gradual, the patient is not as ill, sputum production is minimal and the gram stain fails to reveal a predominant organism.[4] The most common organisms causing the atypical presentation have been thought to be *Mycoplasma pneumoniae, Chlamydia pneumoniae* (TWAR), *Coxiella burnetti,* adenovirus and *Chlamydia psittaci.*[3,4] However, a recent study has suggested there is a significant overlap in the presentation of the acute community-acquired pneumonia and the atypical pneumonia syndrome.[1] In other words, the presentation is of little value in determining the etiologic agent.

Dr. Johnson is a family physician with the University of Iowa Department of Family Practice.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR SEPTEMBER 1993

Etiology of community-acquired penumonia

Studies have shown that the specific etiology of community-acquired pneumonia can be found in 50-80% of the cases.[1,3,5,6] In these studies, however, a definitive diagnosis was made using studies not commonly utilized in the clinical setting, so the percentage of cases with a definitive diagnosis in the community setting may be somewhat lower. In most studies a definitive diagnosis is dependent on a positive blood culture, pleural fluid culture, bronchoalveolar lavage, open-lung biospy, isolation of *M. penumoniae* or *Legionella spp.* from sputum culture, serologic studies, heavy growth of predominant bacterial pathogen on sputum culture or light growth of a pathogen which was predominant on gram stain.

S. pneumoniae has consistently been demonstrated to be the most common pathogen in community-acquired pneumonia, accounting for 15-60% of the cases.[1] The rank order of the next most common pathogens vary depending on the study, but include *H. influenzae* (4-15%), *Legionella spp.* (4-15%), *S. aureus* (1-10%), aerobic gram negative rods (up to 20%), *M. pneumoniae* (up to 14%).[1,7-21] The rank order of the most common pathogens according to different studies is listed in Table 1. Other common pathogens include *Moraxella catarrhalis, Chlamydia pneumonia,* viruses (influenza A and B, parainfluenza, respiratory syncytial virus, adenovirus).

In elderly patients, *S. pneumoniae* is still the most common pathogen, but the frequency of aerobic gram negative infections increases as does the frequency of aspiration pneumonia.[3,22] In immunocompromised patients, the clinician must consider *Pneumocystis carinii,* CMV and mycobacteriae in addition to the other pathogens. The incidence of *M. tuberculosis* is also increasing among non-immunocompressed persons and this pathogen must also be considered.[23]

Diagnosis

It is important to establish the etiologic agent so therapy for that agent can be initiated. As already mentioned, the clinical presentation is not specific enough to be helpful in making a diagnosis. In addition, Tew et al have demonstrated that chest radiography is not helpful in determining the causative organism.[24]

TABLE 1

RANK ORDER OF COMMUNITY-ACQUIRED PATHOGENS BY STUDY*

		Rank Order (%)					
Study	*Year*	*First*	*Second*	*Third*	*Fourth*	*Fifth*	*No Dx (%)*
Bath[7]	1964	S.pneum (44)	H.influ (22)	Virus (?)	S.aureus (9)	M.pneum (?)	38
Fekety[8]	1971	S.pneum (62)	Virus (12)	M.pneum (3)	K.pneum (2)	S.aureus (1)	34
Sullivan[9]	1972	S.pneum (62)	GNR (20)	Virus (11)	S.aureus (10)	H.influ (8)	43
Dorff[10]	1973	S.pneum (53)	S.aureus (7)	K.pneum (6)	Influ A (5)	M.pneum (4)	17
Moore[11]	1977	S.pneum (47)	H.influ (46)	S.aureus (14)	K.pneum (14)	Proteus (8)	13
Macfarlane[12]	1982	S.pneum (76)	L.pneu (15)	C.psit (6)	Virus (6)	H.influ (3)	3
Klimek[13]	1983	S.pneum (36)	H.influ (15)	L.pneu (14)	S.aureus (8)	K. pneum (7)	0
Berntsson[14]	1988	S.pneum (54)	M.pneu (14)	Influ A (12)	H.influ (4)	C.psit (2)	21
Marrie[15]	1985	Apiration (15)	S.pneum (9)	H.influ (9)	CMV (6)	Chlamydia (4)	44
Holmberg[16]	1987	S.pneum (39)	H.influ (5)	M.pneu (5)	Influ A (5)	M.catarr (2)	29
Br Th Soc[17]	1987	S.pneum (42)	M.pneu (10)	Influ A (7)	H.influ (6)	C.psit (3)	33
Aubertin[18]	1987	S.pneum (12)	L.pneu (11)	M.pneu (9)	H.influ (3)	K.pneum (3)	49
Marrie[19]	1987	Aspiration (11)	S.pneum (9)	H.influ (6)	Chlamydia (6)	Influ A (5)	37
Levy[20]	1988	S.pneum (26)	H.influ (12)	M.tb (10)	GNR (7)	L.pneu (4)	35
Woodhead[21]	1987	S.pneum (36)	Influ A (6?)	Other vir (12)	H.influ (10)	S.aureus (1)	45
Fang[1]	1990	S.pneum (15)	H.influ (11)	L.pneu (7)	Chlamydia (6)	GNR (6)	33

No DX = percentage of patients for whom no definite etiologic agent could be established. S.pneum = Streptoccus pneumoniae, M.pneum = Mycoplasma pneumoniae, L.pneu = Legionella pneumophilia, H.influx = Hemophilus influenza, S.aureus = Straphylococcal aureus, K.pneum = Klebsiella pneumoniae, C.psit = Chlamydia psittaci, GNR = gram negative rods, M.catarr = Moraxella catarrhalis, M.tb = Mycobacteria tuberculosis.

**Adapted from Fang et al[1]*

The sputum gram stain can be extremely valuable in establishing the diagnosis.[25] The quality of the sputum sample can be evaluated by the criteria proposed by Murray and Washington.[26] An adequate sputum sample should have less than 10 squamous epithelial cells and greater than 25 leukocytes per low-power field. The sputum culture can be helpful if there is one predominant organism which corresponds with the organism seen on the gram stain. The sensitivity of blood cultures is around 15%.[27] Blood cultures should be obtained, however, since a positive culture establishes the diagnosis.

Serologic studies are being utilized increasingly in research studies to establish a specific diagnosis, but their use in clinical practice is still somewhat limited.[1,5] These tests involve detection of bacterial antigens in tissue fluids or antibodies directed against the microorganisms in serum.[28] *S. pneumoniae* and *H. influenzae* antigens have been detected using counterimmunoelectrophoresis, latex agglutination, coagglutination and enzyme immunoassay of body fluids. The sensitivity and specificity are acceptable, but these tests still have not gained wide acceptance. *Legionella pneumophilia* has been diagnosed using direct fluorescent antibody staining of the organism, antigen detection using DNA probes, radioimmunoassay, enzyme immunoassay and latex agglutination.[29]

Diagnosis of *Mycoplasma pneumoniae* has relied on culture of the organism, but DNA probes have been developed which may be useful in the diagnosis.[29] A fourfold increase in specific mycoplasmal complement fixation titers in paired serum samples or a IgM titer of greater 1:4 is diagnostic of *M. pneumoniae*.[33]

Should the patient be hospitalized?

One of the first decisions that a physician must make is whether or not to hospitalize the patient. Several studies have looked at factors which may be associated with a complicated outcome or increased mortality.[27,30-32] Fine et al identified five factors which were independent predictors of a complicated outcome.[27] Age greater than 65 years, comorbid illness (prior history of diabetes, renal insufficiency, congestive heart failure or a hospitalization within one year of presentation), temperature greater than 38.3 degrees Celsius, immunosuppression, or high risk etiology (staphylococcal, gram negative rod, aspiration, or post-obstructive pneumonia) were all predictive of a complicated outcome. This suggests that patients not meeting these criteria could reasonably be treated as outpatients. Zweig et al studied 133 elderly patients hospitalized in a small rural hospital and found that impaired level of consciousness, tachypnea, temperature lower than normal, WBC count higher than 20K and cyanosis were associated with increased mortality.[30]

'Penicillin is still the treatment of choice for pneumococcal pneumonia. However, penicillin resistant stains are increasing in prevalence.'

Treatment

Ideally, antibiotic treatment should be directed by the sputum gram stain. Unfortunately, patients are sometimes unable to provide an adequate sputum sample or the gram stain shows a lack of organisms or multiple organisms without a preponderance of any one type. In this case, the physician must rely on empiric antibiotic coverage.

Penicillin is still the treatment of choice for pneumococcal pneumonia. However, penicillin resistant stains are increasing in prevalence and approximately 3-5% of cases in the U.S. are caused by penicillin resistant pneumococci.[6]

Hemophilus influenza is resistant to ampicillin in 10 to 30% of cases.[29] Because of this, ampicillin can no longer be thought of as adequate empiric coverage for *H. influenza*. A second generation cephalosporin, trimethoprim-sulfamethoxazole, or ampicillin-clavulanate potassium would provide adequate coverage for beta-lactamase producing *H. influenza*.

A large percentage of the time the gram stain will not identify a likely etiologic agent. In this situation the physician must treat the pneumonia empirically. If the patient is not severely ill erythromycin is good empirical treatment and covers *S. pneumoniae, M. pneumoniae, L. pneumophilia, Moraxella catarrhalis* and *Chlamydia pneumoniae*. If the patient is severely ill *S. pneumoniae, H. influenza, L. pneumophilia, S. aureus* and gram negative rods must be covered. A second or third generation cephalospo-

(Continued next page)

rin with erythromycin added if *L. pneumophilia* is suspected is a reasonable choice. If anaerobic infection due to aspiration is suspected, clinadmycin should be added to the regimen.

Preventive measures

For the patients who smoke, facilitating smoking cessation may be one of the most helpful things the physician can do. Cigarette smoking damages the mucociliary defense mechanism and smoking cessation may allow this defense system to recover.

The pneumococcal vaccine probably reduces the chance of acquiring pneumococcal pneumonia by 60-80%, but may be less effective in elderly patients with underlying conditions.[33] The vaccination is benign and should be given to those at risk (the elderly, immunocompromised).

The influenza vaccine is 70-80% protective for the current covered strains and should be administered yearly to patients older than 65, residents of long-term care facilities, and those patients with chronic cardiac, renal, or hematologic illness.

Summary

Pneumonia is one of the most common infectious illnesses treated by primary physicians. Accurate diagnosis requires a thorough history and physical examination, supplemented by a chest x-ray to confirm the presence of pneumonia and an adequate sputum sample to establish the etiologic agent. Empiric treatment is guided by a knowledge of the most likely organisms and their sensitivities in a particular community.

References

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This article was written by David Weiss, chairman, education committee and Mark Templeton, executive director, Iowa Medical Group Management Association.

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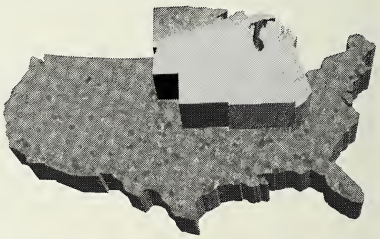
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John Anderson, M.D.

Our world turns upside down

THE SAGA OF HEALTH SYSTEM REFORM continues. Experts agree managed competition will be a hallmark of the Clinton plan. Organized delivery systems will be developed and hospitals and physicians will compete for patients. If health system reform is to be meaningful, physicians and hospitals must form strong partnerships. A new option for these partnerships is an organized delivery system, called a Physician Hospital Organization (PHO).

In the past, hospital administrators and physicians have often been wary of one another. Hospitals have been buying up practices and setting up satellites. Physicians have openly competed with hospitals by setting up their own laboratories, diagnostic centers and surgicenters.

With health system reform upon us, hospitals are our natural ally. Under the new system, the market will demand that providers operate as an integrated contracting entity capable of managing quality and assuming and managing financial risk through capitated payments. The market will demand the ability to contract for all health care services through one source (single point contracting).

Daniel Zisner, Ph.D., a consultant in the establishment of Physician Hospital Organizations in Iowa, predicts hospitals and physicians will have to organize into some type of integrated single point contracting entity to remain viable in the marketplace. Proof of quality will be a definite requirement of any entity.

A PHO is one option which will allow physicians to work with hospitals as an integrated entity without wholesale consolidation. In such a system, traditional thinking has to be completely reversed. What a hospital now considers a profit center (e.g., lab and x-ray) becomes a cost center. What a physician considers a profit center (e.g., procedures and surgery) becomes a cost center.

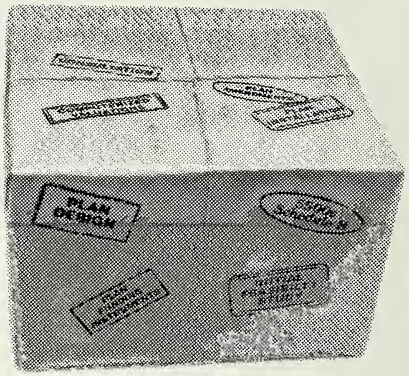
Dr. Zisner also predicted employers will form coalitions and buyer trusts to exercise more market leverage. Hospitals will develop owned primary care networks and merge into large conglomerates. Group practice formation will accelerate and physicians will be more willing to be employed. Dr. Zisner warned hospital administrators that physicians cannot be viewed as a cost-accounted department of the hospital. Physicians must be permitted to administer and govern physicians. Physicians must be partners—not just employees.

Does this sound as though our world has been turned upside down? We will have to be adaptable, but this is an opportunity for physicians and hospitals to be joint leaders. The IMS and the Iowa Hospital Association traditionlly have worked well together and have agreed on many key issues. I believe in the future the IMS and the IHA—like you and your hospital—will establish a very close relationship, perhaps even a partnership.

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Faith

Nothing in life is more wonderful than faith—the one great moving force which we can neither weigh in the balance nor test in the crucible.
—Sir William Osler (1849-1919)
British Medical Journal 1:1470, 1910

THE PRACTICE OF MEDICINE is irrevocably intertwined with faith. The physician must have faith in knowledge and skills learned by experience. If one's abilities are lacking, the results will be failure. The knowledge possessed by the physician should enable the successful practice of medicine. Yet, if the physician is unsure of the abilities expected by professional colleagues and ultimately by patients abject failure may ensue.

The skills of medical practice entail the basic knowledge of procedures of diagnosis and treatment. The actual involvement in diagnosis and treatment requires a degree of faith commensurate with those abilities. The physician without faith in practice abilities will result in a patient in a state of confusion . . . confusion as to the nature of the illness at hand, the abilities of the physician, as well as the quality of medical care received. This is not to say that an attitude of faith is synonymous with being "cock-sure" about one's abilities. Such an attitude by the physician can erode the patient's confidence because it may appear as a sham regarding the true abilities of the physician.

This brings us to the other side of the cooperative relationship between the physician and the patient. The success of recovery over illness depends largely upon the faith the patient may have in the physician as well as the treatment modalities offered. That faith by the patient must be earned by the actions of the physician demonstrating professional knowledge and skills. There is speculation that the mental state of the patient plays a prominent role in recovery from illness.

It is a two-way street. Have sincere faith in yourself, doctor, and the faith of the patient will be enhanced. The end result will be medical care given in an environment of satisfaction and gratitude.

Shared decision-making tested in Iowa

In cooperation with Iowa hospitals and physicians, Blue Cross Blue Shield is testing a video program that helps patients participate in their treatment decisions.

Cindy Hochart, R.N.
Des Moines, Iowa

FOR MANY YEARS IOWA has been on the forefront of computer technology which advances the way doctors care for patients. Into this environment comes a new technology built on the premise that well-informed patients make better health care decisions and are happier with their health care. This technology uses an interactive video disk system in a program for patient education. The Shared Decision-Making Program (SDP) is being evaluated in Iowa in a pilot study sponsored by Blue Cross Blue Shield of Iowa (BCBSI) in cooperation with certain Iowa hospitals and physicians.

The SDP is produced by the Foundation for Informed Medical Decision-Making, a non-profit organization in Hanover, New Hampshire. Using interactive computer and laser disk technology, individualized outcomes research information is provided to patients for specific clinical conditions.

The video programs are focused on a particular decision faced by the patient and physician regarding treatment options. There are five video programs available and about 30 in various stages of development. The five programs available in Iowa deal with mild hypertension, Benign Prostatic Hyperplasia (BPH), low back pain (generalized, herniated disk or spinal stenosis), breast cancer surgery and breast cancer adjuvant therapy.

Interactive technology

This system differs from other educational videotapes because it educates patients



Patients control the interactive video programs which help them make informed treatment decisions.

Cindy Hochart is a research analyst with Blue Cross Blue Shield of Iowa.

through interaction. The system, which consists of a modified microcomputer, a laser disk player and a printer, is interactive in two ways.

First, the computer is equipped with a special card that allows the patient to enter certain pertinent information into the program. Using this patient information, in combination with findings from scientific outcomes research, the computer calculates outcome probabilities specifically for that patient. For example, the patient with mild hypertension is asked to report blood pressure, age, sex, race and other lifestyle factors that affect hypertension. The information the patient sees is tailored to reflect the clinical and demographic characteristics.

SDP is also interactive through the Learn More section. A portion of the program meant to be pertinent to all patients is followed by a section that allows the patient to get more information on a topic only briefly covered in the body of the program or to get information on additional topics related to their condition. Certain cancer patients for example, may not be comfortable hearing survival statistics, while others feel survival information is essential to their decision-making process.

Four step program

The SDP is designed to expand the information available to the patient and enhance the relationship with his or her physician, not to replace any part of the physician service. The SDP is essentially a four step program:

1. *Initial physician visit.* The patient is diagnosed by the physician and is identified as being an eligible program candidate. Each condition has a list of eligibility and exclusionary criteria.

2. *Advance materials.* The patient is given an educational booklet describing his or her condition and treatment options and a referral form completed by the physician. (Without a referral from a physician, the patient is not eligible to participate in the SDP.)

3. *Viewing session.* Information from the referral form is entered into the computer by a nurse, office assistant, librarian or patient. Patients may bring family members or other members of their support group to the viewing session. At the conclusion of the viewing session a printed summary will be provided to the patient. An additional copy will be produced for the physician.

4. *Post-viewing appointment.* After the viewing session, the patient schedules an appointment with the physician. This visit is for a review of the information, an opportunity to ask questions and to make decisions with the physician regarding treatment options.

(Continued next page)

Iowa pilot evaluates SDP and patient satisfaction

HOW WELL THE shared decision-making interactive video promotes patient education and informed consent is yet to be firmly established. Early studies suggest 90% of participating patients view the SDP as positive, but more research is needed to understand the effect of the SDP.

Blue Cross and Blue Shield of Iowa, in cooperation with certain Iowa hospitals and physicians, is launching a pilot study to evaluate the effect of the SDP on patient decisions and patient satisfaction. The SDP will be available to all patients in the pilot areas with a physician referral, regardless of insurance coverage. The study uses a pre/post survey research design to evaluate patient satisfaction and to track patient decisions. The patient will be followed over a period of time to track changes in initial treatment decisions and satisfaction. Results of the study will be analyzed by the Health Services Research Department of BCBSI; findings will be shared with all participating provider partners.

The initial pilot will be conducted in Des Moines and surrounding communities. All necessary materials will be provided by BCBS of Iowa. For additional information or to receive program materials for pilot participation, call 515/248-5272 or 515/248-7072 or write to: Cindy Hochart, research analyst, Blue Cross and Blue Shield of Iowa, 636 Grand Avenue, Station 116, Des Moines, Iowa 50039.

SDP benefits patients

The SDP offers potential benefits to physicians, insurers and the health care system in general, but the biggest benefactor is the patient. The SDP provides scientific outcomes research information to patients in an understandable format.

Each program begins with a general discussion of the condition. The discussion then turns to treatment options and the patient is given individualized outcomes probabilities. For example, in the breast cancer surgery video, the patient is given the probability of cancer recurrence after modified radical mastectomy and after breast sparing lumpectomy, given her age. The final chapter is the 'learn more' section which allows the patient to view additional information of interest.

'When patients are involved in their health care decisions they feel greater ownership for those decisions and are generally more satisfied with the care they receive.'

Because the patient schedules the viewing session at his or her convenience, they receive the information at a time when they may be more receptive to learning. In the traditional patient education environment, the physician may try to educate the patient during a time of emotional distress, such as after delivering the diagnosis of breast cancer.

Another benefit of the SDP is that the patient is encouraged to play a larger role in choosing treatment options. When patients are involved in their health care decisions they feel greater ownership for those decisions and are generally more satisfied with the care they receive. Research has also shown that if patients are involved in their health care decisions, they are generally more compliant. This may lead to better health care outcomes and improved patient satisfaction.

Many patients feel that the relationship with their physician is enhanced by the SDP. One patient, quoted in the March 1992 issue of *Business and Health*, attributed the change to the fact that he felt more knowledgeable. Being better informed about the condition reduces barriers to communication. Patients can focus attention on key issues including their personal feelings and values as they make a treatment decision.

SDP Benefits physicians

The improved patient compliance and improved retention of information can result in physicians spending less time going over the same information several times. Physicians also like the uniform delivery of key information to all patients.

Many physicians feel the SDP reduces their risk for malpractice litigation. When the patients are fully engaged in the decision-making process and the relationship with the physician is good, the patient is less likely to bring suit. If a malpractice suit is filed, the physician can demonstrate thorough patient education by virtue of the summary provided to each patient and physician after viewing the SDP. The summary includes patient specific outcome probabilities and becomes a permanent part of the patient's medical record.

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New, improved 'Care for Kids'

Providing care for Iowa's low income children is much easier through 'Care for Kids,' a revamped version of the Early Periodic Screening, Diagnosis and Treatment program.

Alfred Healy, M.D.
Iowa City, Iowa
Charles Danielson, M.D.
Des Moines, Iowa

EPSDT—IT'S ANOTHER ONE of those confusing acronyms. It is a program that Iowa primary care providers should know more about—*Early Periodic Screening, Diagnosis and Treatment*. EPSDT offers you a way to provide better health care to more of your young patients.

EPSDT services are provided through Medicaid to children from low income families. In the past, physicians were often less than enthusiastic about participating in this program because of cumbersome paperwork and low reimbursement. Today, that has changed. When you participate in this program, now called "Care for Kids," you will find that paperwork is minimal and reimbursement rates reasonable. These changes were made to improve access to comprehensive care for Iowa's children.

You are probably all too familiar with this scenario:

The parents of a 30-month-old child, Lucita, bring her to your office for the first time with the complaint that she is short of breath. During her exam, you find wheezing and other signs of bronchial constriction. A diagnosis of asthma is obvious. As you discuss Lucita's health history with her parents, you learn that her only formal health care has been provided through visits to the emergency room for episodes like the one that brought her to you.

Lucita's parents are employed, but have no health insurance. They are unaware Lucita is eligible for care through Medicaid.

Lucita received her childhood immunizations through the county immunization clinic. Although her asthma is not severe and could be managed without resort to an emergency department, her parents are too anxious to talk with you about ongoing, coordinated care. You realize you will need to build a relationship with them before you can provide the health care guidance they need.

You have probably experienced such a situation before. A more comprehensive screening might find that Lucita has iron deficiency or is delayed in speech or other development. Children from low income families have more than their fair share of illness and injuries, but good health care can prevent or

(Continued next page)

Dr. Healy is a UI professor of pediatrics. Dr. Danielson is medical director of the Iowa Department of Public Health Division of Family and Community Health.

minimize serious complications later in a child's development. Iowa's Care for Kids program, earlier known as EPSDT, makes it much easier for you to provide such care for Lucita and other children like her.

What's new about Care for Kids?

The EPSDT program has been around for nearly 20 years. However, it is only recently that serious efforts have been made to make it easy to use, to inform health care providers about it and to encourage them to use it. A newsletter about child health care issues will be sent to all Iowa primary care providers beginning this fall.

As it began working to make EPSDT more effective, the Iowa Department of Human Services (DHS) listened to the suggestions of private providers. Because a common complaint was cumbersome paperwork, this has been streamlined so that EPSDT screening claims are now submitted on the familiar HCFA 1500 form, using an EPSDT check-off box. This also makes electronic submissions possible.

A second complaint was the reimbursement was inadequate. As a result, reimbursement rates for screenings have been increased by 50%, to $38, effective July 1, 1993.

Why is this program so important?

In Iowa, about 165,000 children received medical assistance in 1992. Nineteen thousand Iowa children were screened through EPSDT services—about 11% of the children eligible for these services. The federal Omnibus Budget Reconciliation Act (OBRA) of 1989, recognizing that comprehensive well-child care is crucial, requires that 80% of all eligible Iowa children be current on screenings by 1995. Failure to reach this goal puts the state at risk of losing federal Medicaid financial participation.

Studies have shown that Iowa children who participate in Medicaid and receive an EPSDT screen average $46 per year less in health care expenses than children who are not screened. In 1992 alone, screening of all eligible Iowa children might have saved the state more than $6 million. If each Iowa primary care physician carried out an average of three EPSDT screenings per week, all eligible children could be screened each year.

The Care for Kids program provides funding for the care of Medicaid-eligible children from birth through their 21st year. Through Care for Kids, these children have access to comprehensive health assessments on a regular schedule as recommended by the American Academy of Pediatrics.

If a screening indicates a child may have a health concern, further diagnosis and treatment are provided. In most cases, the physician initiates diagnosis and treatment during a child's first visit. If a child has more complex medical needs, the physician will provide the referral. Care is reimbursed through the EPSDT program.

What does participation require of you?

Participation in the Care for Kids program involves supervision of a child's health care and billing the program for reimbursement. The periodic screenings called for by the Care for Kids program follow the schedule of the American Academy of Pediatrics. This schedule is available by calling the Iowa Department of Public Health Division of Family and Community Health. Screenings at intervals other than those on the AAP schedule are now allowed if a child has need, or has not been screened. During a child's comprehensive health screen, you will:

- **Take a health and developmental history**—A child's health and developmental history should include information about the child's nutritional status, physical health and mental health.
- **Perform a complete physical examination**—The child should receive a complete, unclothed, head to toe physical examination, with all of the usual listening, observing and feeling.
- **Arrange for appropriate tests**—Appropriate screening tests include hematocrit or hemoglobin, urine dipstick, and blood lead levels.
- **Provide health education and anticipatory guidance**— Health education and anticipatory guidance should be adapted to meet the needs of the child and the family.

Coordinating care

Most physicians don't have a lot of time to coordinate care for their patients. In the face of projected shortages of primary care provid-

ers, it is more important than ever to eliminate fragmented, poorly coordinated services. A Medicaid administrative option for more effective, efficient use of Care for Kids resources can be provided to support interagency cooperation among community health, school and social services staff so children participate in screenings and get appropriate services. Through this option, your local public health nurse can play an expanded role. In addition, with this option local public resources are used as the state "match" to bring in federal financial participation.

For example, a nurse who identifies an eligible child might gather a basic health history, perform a developmental screening, conduct a home assessment, then refer the child to the physician. The physician could confirm or expand upon the nurse's assessment. If you recommend treatment, the nurse can assist the family in following your recommendations. Public schools and public health nursing services in both cities and counties are being encouraged to pursue this role.

'When you participate in this program, now called "Care for Kids," you will find that paperwork is minimal and reimbursement rates reasonable. These changes were made to improve access to comprehensive care for Iowa's children.'

Efforts are currently underway to use available federal resources to strengthen community efforts such as Care for Kids, so all of Iowa's children have access to adequate health care. Contact your local child health center, public health nurse or the author at the Iowa Department of Public Health, 515/281-4912, to learn what is happening in your local community.

It is simple to help a child get health care through the Care for Kids program and it can make a real difference in the quality of life for that child. If you have questions about the Iowa Care for Kids (EPSDT) program, call: Sally Nadolsky, Bureau of Medical Services, Iowa Department of Human Services, 515/281-5796.

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Watch for the All New *IOWA MEDICINE*

The debut of the new *IOWA MEDICINE* magazine is set for January, 1994. The magazine will contain a science and education section and socioeconomic news which is now published in newsletter form. Subjects covered in the new publication will include legislation, practice management, medical economics and IMS newsmakers.

Representatives of major specialty societies in Iowa met in August at IMS headquarters to discuss the scientific content of *IOWA MEDICINE* and recommendations of the IMS strategic planning committee on communications. These specialty society representatives will serve as members of the *IOWA MEDICINE* Scientific Panel which will advise staff on the scientific content of the magazine during 1994.



Alan Beste

Guarding the health of student athletes

The author, wellness coordinator for the Iowa High School Athletic Association, discusses that group's efforts to eliminate unsafe weight loss practices among Iowa's high school wrestlers.

What are your duties as wellness coordinator for the Iowa High School Athletic Association?

In 1989, the Iowa High School Athletic Association (IHSAA), became the first, and remains the only, state high school activities association to employ someone whose primary duties are to safeguard student-athlete health and wellness. The Athletic Association is very proud of the fact that our member schools have made the commitment to begin the only program of its kind in the country. My duties as wellness coordinator include developing health and wellness related materials and programs and giving presentations regarding health, safety and wellness issues important to student-athletes, their parents and coaches.

I also act as one of the liaisons between the IHSAA and the Committee on Sports Medicine of the Iowa Medical Society. The relationship between our two organizations has resulted in the production of educational posters, a videotape addressing the issue of contracting bloodborne pathogens in an athletic setting, development of a new pre-participation athletic examination form, a videotape regarding weight control in wrestling and a body composition testing program for high school wrestlers.

A study published in this month's *IOWA MEDICINE* concludes that weight loss through dehydration and starvation continues to be prevalent among high school wrestlers. Do you agree with the conclusions of the study?

I am encouraged that the study also states that wrestlers meet the recommended daily servings for two food groups and water. My guess is that very few high school students, or adults, meet the daily recommendation for all food groups.

While improper methods of weight loss may continue by some wrestlers, the success achieved by the IHSAA, school administra-

tors, coaches, parents, physicians and other medical professionals over the past 20 years should not be minimized. Two-thirds of the high schools in Iowa currently utilize body composition testing to predict a safe, minimal wrestling weight for their wrestlers. Many wrestling schools are offering educational programs regarding proper nutrition and proper methods of weight control.

For over 20 years the IHSAA, the Committee on Sports Medicine of the Iowa Medical Society and the Scanlon Foundation funded studies regarding weight control in wresting. This issue continues to be addressed from the education perspective. I believe the key to eliminating dangerous methods of weight control in wrestling is to provide sound, accurate information on nutrition and weight loss to wrestlers, their coaches and parents. Then we must provide the motivation for them to utilize that information.

Do you know of any high schools in Iowa whose wrestlers win without starving to "make weight"?

For the past several years, the IHSAA has studied selected high school wrestlers from the time their body composition is measured (prior to the beginning of the wrestling season) through the state tournament. The results of this informal survey indicate there are high school wrestlers competing in the state tournament who are above their safe, minimal weight and who have not used dehydration and fasting as weight loss techniques.

I believe those who work closely with high school wrestlers in Iowa (coaches, parents, school administrators, the IHSAA, school nurses and team physicians) would admit that the concerns of rapid weight loss have not been eliminated, but have been greatly reduced.

We understand the IHSAA has produced a video on weight reduction and high school wrestlers. What is the purpose of the video and what does the IHSAA plan to do with it?

This recently produced 15 minute video entitled "Wrestling Nutrition and Weight Control" is designed to provide accurate, well-documented information regarding proper nutrition and weight control for high school

(Continued next page)

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

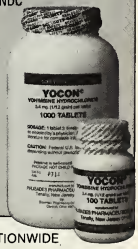
Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.

References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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wrestlers. It will be made available for all junior and senior high schools in the state which have a wrestling program.

We encourage every school with a wrestling program to show this video to wrestlers, coaches and parents. We believe it emphasizes the need for medical professionals, parents and schools to work together in making wrestling as safe an environment as possible. We would be very happy to loan the video to physicians and other medical professionals throughout the state.

What can physicians do to help convince high school wrestlers that certain weight loss practices are unhealthy and unsafe?

I believe the ideal time for physicians to visit with wrestlers about proper weight control is during the pre-participation athletic physical examination. The newly developed physical examination form asks what was the most and the least the athlete weighed during the past year. That question could serve as a great beginning for such discussions. Student-athletes are concerned about academic, as well as athletic performance. This may be one point of emphasis on good nutritional practices.

Letter to the Editor

Flood-related upper respiratory infections

Dear Editor:

I recently read your letter concerning the flooding in Iowa that appeared in the *Alabama MD Bulletin.* As people return to their flooded homes and businesses, Iowa physicians may see an increase in the incidence of upper respiratory infections related to heavy ingestion of mold or mildew spores. This is sometimes an insidious ailment that is usually thought to represent influenza, pneumonia or an asthmatic reaction. We have seen it in a few patients following flooding in the city of Mobile.

As you might well imagine, since all of the floors and walls have become flooded, mold and mildew may grow in the walls, under the floors and in the ceilings without the knowledge of the occupants. Ventilation systems will be particularly prone to development of this mold and mildew and could conceivably cause a significant outbreak of this

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type of problem for the people who return to their homes and businesses.

We can well empathize with the magnitude of your problem, since our city suffered a head on collision with a hurricane in 1979. *—Ralph Pfeiffer, Jr., M.D., Mobile, Alabama.*

New coalition aims to reduce childhood injuries in Iowa

IN RESPONSE TO THE GROWING number of children unintentionally injured and killed, injury prevention activists from Iowa have established the Iowa SAFE KIDS Coalition. The Iowa Department of Public Health is the lead agency for the coalition, which is an affiliate of the National SAFE KIDS Campaign in Washington, D.C. The mission of the state coalition is to reduce childhood injuries that require costly emergency medical treatment. Most of these injuries are preventable through education, safety precautions and safer environments.

Preventable injury is the number one killer nationwide of children age 14 and under. Iowa follows the national trend. The latest data show 1,407 serious injuries to children 0-14 were reported to the Iowa Central Registry for Brain and Spinal Cord Injuries in 1991. Of those, 1,266 were traumatic brain injuries, which temporarily or permanently impair a child's physical or cognitive functions. An additional 24 suffered injuries to their spinal cord or vertebrae. Of the traumatic brain injuries, 35% were caused by falls, the most common cause. Statistics are reported to the central registry by approximately 83% of Iowa hospitals and represent only those children actually admitted to the hospital.

Goals of the coalition include building an effective childhood injury prevention network of local, community-based coalitions. By uniting diverse groups in the state and local coalitions, Iowa can develop innovative injury prevention educational activities, initiate public policy changes and raise public awareness of injury prevention issues.

The Iowa SAFE KIDS Coalition is open to anyone concerned with preventing unintentional injuries to children. For more information contact Victoria Halsted, Iowa SAFE KIDS Coalition coordinator, c/o IDPH, Lucas State Office Building, Des Moines, Iowa 50319-0075; 515/281-4906.

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Iowa wrestlers continue detrimental weight loss practices

Rapid weight loss continues to be deeply ingrained in the sport of wrestling, despite the fact the medical community considers such practices detrimental to the physical well-being of athletes.

Megan Woodworth, M.Ed
Michael Sitler, Ed.D.
Red Oak, Iowa

WRESTLING IS A SPORT which matches males of equal weight by setting strict weight classifications for competition. A debate between wrestling coaches and the scientific and medical communities exists as to how participants reach and maintain weight classifications. Many coaches consider rapid weight loss to be an essential part of the sport while the scientific and medical communities contend such practices are detrimental to the physical well-being of wrestlers.

Although many studies have identified the detrimental effects of weight loss on performance, the practice continues to be an intregal part of wrestling. Approximately 20 years ago, the Iowa Wrestling Studies were conducted by researchers at the University of Iowa. In addition to developing an equation to determine a wrestler's minimum body weight, these researchers identified a ritual of weight loss practices that were deeply woven into the fabric of the sport. Using excessive exercise, dehydration, and withholding of food, the average weight loss was 10% of the wrestler's preseason body weight.

Tipton and Oppliger in 1984 questioned whether a wrestler was victorious because of his athletic ability or because he was better able to withstand the biochemical/physiological variability associated with weight loss. In 1990, Lakin, Steen and Oppliger found that high school wrestlers utilized the same weight loss methods as the wrestlers studied twenty years earlier in the Iowa Wrestling Studies. These authors also reported that high school wrestlers experienced moderate to severe fatigue, anger and anxiety while trying to lose weight as well as depression and low self-esteem.

The effects of rapid weight loss on the body when extended over the four months of the competitive season during the four years of a high schooler's career continue to be of concern, considering that the majority of wrestlers and wrestling coaches know very little about the detrimental effects of rapid weight loss.

Results and discussion

On average, the subjects were 16.4 ± 1.2 years old, had 2.5 ± 1.2 years of high school wrestling

Ms. Woodworth is a certified athletic trainer working in the clinical setting. Dr. Sitler is the graduate coordinator in the Department of Physical Education at Temple University, Philadelphia, Pennsylvania.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR OCTOBER 1993

experience and had competed in 2.5 ± 1.0 high school sports per year. The sample as a whole decreased their body weight by an average of 11.9 ± 8.1 pounds (7.5% ± 4.6) in 12 ± 12.9 days from an initial average body weight of 158.8 ± 36.3 pounds. When analyzed by class (size) of school, 3A wrestlers lost a significantly greater percent of their body weight [$F(2, 177) = 6.95$, $p = .001$] over a greater number of days [$F(2, 170) = 6.41$, $p = .002$] than did 2A and 1A wrestlers. Thus, the wrestlers in this study

'The effects of rapid weight loss on the body when extended over the four months of the competitive season during the four years of a high schooler's career continue to be of concern.'

exhibited rapid weight loss behaviors similar to those reported in previous studies (Lakin *et al*, 1990; Steen & Brownell, 1990; and Tipton & Oppliger, 1984).

The results of this study suggest that high school wrestlers have become more educated in the area of nutrition than their predecessors. This point is illustrated by the fact that the mean score of 60% (7.8 ± 2.8 out of 13) for the subjects in this study was slightly higher than that of the mean score of all subjects (55%) and the isolated mean score of the wrestlers (52%) in the study conducted by Douglas and Douglas (1984). Increased utilization of medical personnel for nutritional information may be a factor as to why the average nutritional knowledge score of wrestlers in this study was higher than previously reported.

It appears that today's wrestlers are inculcated with the concepts of nutrition to a greater extent during their scholastic education than was previously the case. Health courses are generally taken during the freshman and sophomore years in Iowa schools. Thus, in theory, earlier exposure to sound nutritional information should enable wrestlers to apply that knowledge to appropriate dietary practices.

With a mean score of 2.1 (30%) out of a possible 7, the wrestlers in this study had poor dietary practices. This was true regardless of class (size) of school. The wrestlers in this study met the daily recommended servings for only two of the four basic food groups and water. Their dietary practices have changed little from previous generations of wrestlers. The scientific community recognizes these practices, at the very least, as symptoms of semi-starvation and dehydration and, at the extreme, as an eating disorder.

The wrestlers in this study ranked coach (30.9%) and medical personnel (17.6%) as their first and second most frequently consulted sources for information on weight loss. From the current study, wrestlers appear to be consulting medical personnel increasingly more frequently in this regard, which is encouraging. It is possible today's athletes have greater accessibility to, and are more accepting of the medical community's input on weight loss.

Excessive exercise was the most popular method of weight loss for the wrestlers in this study (36.7% of the collapsed sample; 42.3% of the 3A sample; 27.4% of the 2A sample; and 40.5% of the 1A sample). Wrestlers have changed very little from the practices of their predecessors leading to the conclusion that the method of weight loss is one that is handed down from one generation of wrestlers to the next.

With respect to health, the wrestlers as a whole indicated they felt more fatigued during the competitive season (58%) but had about the same susceptibility to colds/flus (50.8%). Steen and Brownell (1990) reported that 35% of the high school wrestlers they surveyed experienced moderate to severe fatigue when trying to make weight.

When analyzed by class (size) of school, several interesting patterns developed regarding the perception of fatigue and susceptibility to colds/flus: 2A wrestlers reported being more fatigued and having a greater susceptibility to colds/flus than 3A wrestlers, whereas 1A wrestlers reported no change. An explanation for these differences could be that 2A wrestlers (2.8) participated in a significantly ($p < .0441$) greater number of sports per year than their 1A (2.4) and 3A counterparts (2.4). By participating in 2.8 sports per year, 2A wrestlers may be considered as "year-round" athletes meaning that they go from one sport to another with very little time off between seasons. This could increase their perceptions of fatigue and susceptibility to colds/flus due to the fact that they may not get adequate rest.

Over 55% of the total sample reported that weight loss was necessary to achieve wrestling

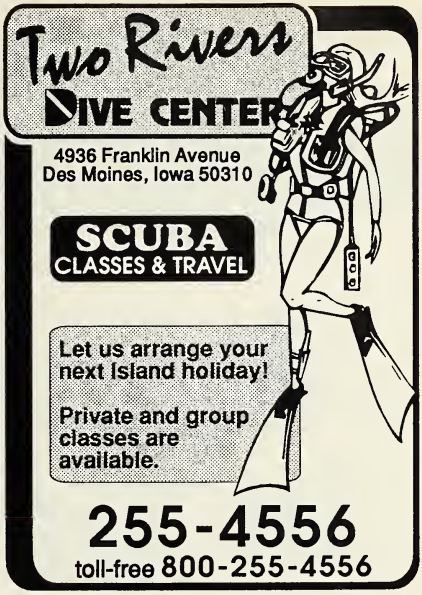
success. The 1A and 3A wrestlers felt weight loss was necessary for wrestling success while 2A wrestlers did not. Of interest is that 2A wrestlers lost significantly less weight during the season (6.5% body weight or 9.9 pounds) than did 3A wrestlers and they started the season with the lowest body weight (151.5 pounds) of all three levels of wrestlers.

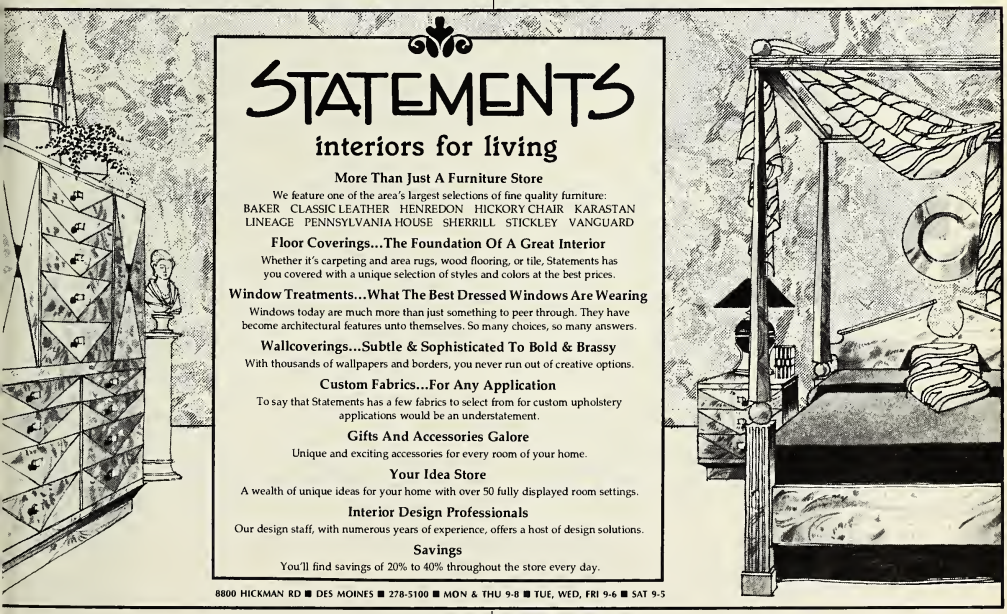
Conclusions

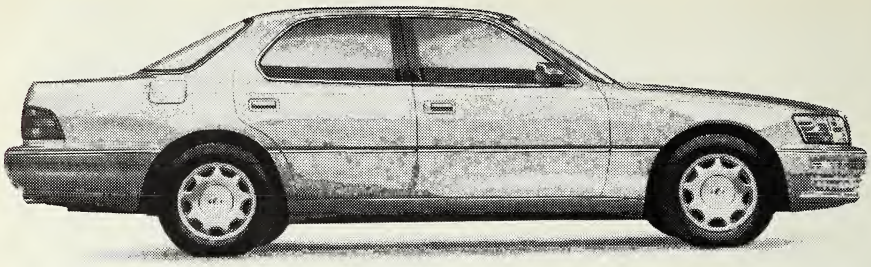
Although the wrestlers in this study possess greater nutritional knowledge and consult more reputable sources of information on weight loss than their predecessors, their dietary practices are less than acceptable. A strong background in nutritional knowledge and a trusted source of information on how to utilize that knowledge should bring about positive behavioral changes. However, the weight loss ritual is deeply ingrained in the sport of wrestling and to change that practice, a new standard of success must be achieved.

Bibliography

A bibliography is available from the authors or the editors of *IOWA MEDICINE*.







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Cooperative Cardiovascular Project: committee updates

THE IOWA FOUNDATION FOR MEDICAL CARE (IFMC) was selected by the Health Care Financing Administration (HCFA) as one of four PROs to pilot the Cooperative Cardiovascular Project (CCP). Through the CCP, the IFMC will cooperate with Iowa's medical community to improve the quality of care provided to Medicare beneficiaries admitted to hospitals with an acute myocardial infarction or those who undergo either coronary artery bypass graft or percutaneous transluminal coronary angioplasty.

Study groups for each of these three areas have been formed to examine the data collected through the Uniform Clincial Data Set System (UCDSS). The myocardial infarction (MI) study group met June 30 to review data collected to date for the MI algorithms created to evaluate the appropriate use of aspirin, heparin, IV nitroglycerin and thrombolytic therapy in the treatment of patients with acute MI. The study group reviewed the data to ensure the data collection and algorithms appropriately reflect care provided to patients in Iowa hospitals.

Analysis of the data indicate additional algorithm refinements are necessary to redefine a number of data variables collected by the CCP abstractors. The MI study group has also recommended changes to HCFA that would provide additional locations in the medical record where abstractors could collect data.

A second committee—the Provider Quality Initiative Committee (PQIC)—met July 7. This committee is comprised of representatives of various state medical societies and health care associations as well as a consumer representative. The PQIC committee is responsible for the general oversight of the data, review of data at state and local levels, recommendation of the most appropriate methodologies for community education and distribution of the data to hospital administrative and medical staffs.

'Through the CCP, the IFMC will cooperate with Iowa's medical community to improve the quality of care provided to Medicare beneficiaries admitted to hospitals with an acute myocardial infarction.'

PQIC will also maintain an active role in carrying out activities in HCFA's Health Care Quality Improvement Initiative which was implemented October 1, 1993 through all PROs. The PQIC committee will meet again once sufficient data have been collected for review and validation prior to release to the medical community.

Formal data analysis has not begun for either coronary artery bypass or percutaneous transluminal coronary angioplasty. HCFA requested the IFMC test the preliminary CABG and PTCA algorithms by abstracting 60 cases. The IFMC performed this abstraction during July. HCFA expects the algorithms for these procedures to be released this Fall.

For more information about the CCP, the committees, or committee findings, contact Pam Thoeming, program manager, at 515/222-2420.

This article was written by Timothy Kresowik, M.D. of the University of Iowa, the IFMC's principal clinical coordinator.

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Richard Nelson, M.D.

PHYSICIANS WITH RECOGNIZED deficiencies in the practice of medicine may benefit from a structured remediation plan. The physician must be motivated to participate in the experience and must not have a cognitive deficit or other condition that compromises learning. Physicians with global deficiencies in the care of patients cannot generally be assisted by a focussed educational program. Comprehensive retraining or a career change may be necessary for these doctors.

Constructing an educational plan necessitates a clear understanding of the problem and negotiation between the physician and educators (and often the referring entity) on the types of experiences likely to accomplish the objectives of remediation.

The steps should include:

1. Identification and verification of deficiencies in medical management.

2. Referral to an educational program for remediation. Such programs are generally available only in academic medical centers, usually administered through continuing medical education offices.

3. Determination by the educator or team that remediation is practical in the setting. Most centers will have limited capacity to develop programs encompassing many practice arenas. Capacity is limited by the availability of faculty who are competent to design a program or administer the process. In other situations there may not be adequate educational resources to implement a plan.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

4. Construction of the plan must be responsive to the capacities of the educators and the learner. Each plan will of necessity be specifically centered on the needs of the individual. The plan may include attendance at didactic sessions (conferences, lectures), participation in clinics, readings and the completion of a project by the learner. Such a project could include a thorough written discussion of a patient management problem, supported by a literature review. A presentation may also be provided verbally to the educational team.

'Construction of the plan must be responsive to the capacities of the educators and the learner. Each plan will of necessity be specifically centered on the needs of the individual.'

5. Evaluation of whether the learner has achieved the educational objective is essential. An evaluation might include the written project previously described, or an examination developed for this purpose.

6. The educator should certify to the referring entity that the physician has participated in remediation and also communicate the results of the evaluation. The educator cannot usually certify **competency** since that must be assessed in the practice setting.

7. A community-based follow-up plan must then be developed to monitor the physician's practice.

Ethical analysis of cases

Robert Weir, Ph.D.

As the field of biomedical ethics matures, it becomes more specialized. One of its specialized features, usually called clinical ethics, involves the ethical analysis of problematic clinical cases.

Such an analysis can be done in the abstract, as happens in the biomedical ethics course I teach at the UI College of Medicine. Students learn how to do an ethical analysis of published clinical cases, thereby developing analytical skills that will help them later in their clinical decision making.

The ethical analysis of cases can also take place in various clinical settings, as when I am asked to do an ethics consult on a problematic clinical case. I work with the attending physician, other physicians and health care professionals, the patient and sometimes the patient's surrogate or family. My goals are to address ethical problems identified in the case, to identify other ethical problems in the case that may not have previously been considered, and to give appropriate advice.

The cases are usually complex and difficult, both medically and ethically. All cases, however, have ethical aspects and require decisions by patients and physicians concerning what the patient wants and/or what the physician thinks ought to be done to respect the patient's autonomy, promote the patient's welfare, avoid harming the patient or balance competing claims in a fair and just manner. Analyzing the ethical aspects of medical cases is a skill related to clinical decision making that can be helpful in regular, fairly straightforward office visits and hospital rounds as well as in cases taking place in tertiary care settings.

I recommend the following format for the ethical analysis of cases. First, gather and interpret the relevant data: (1) identify the significant medical factors in the case (including diagnosis, patient's decision-making capacity, and prognosis with and without treatment); (2) identify the significant personal and/or social factors related to the patient and the patient's health care (patient's values, religious beliefs, preferences, family situation); and (3) identify the ethical problem(s) raised by the case.

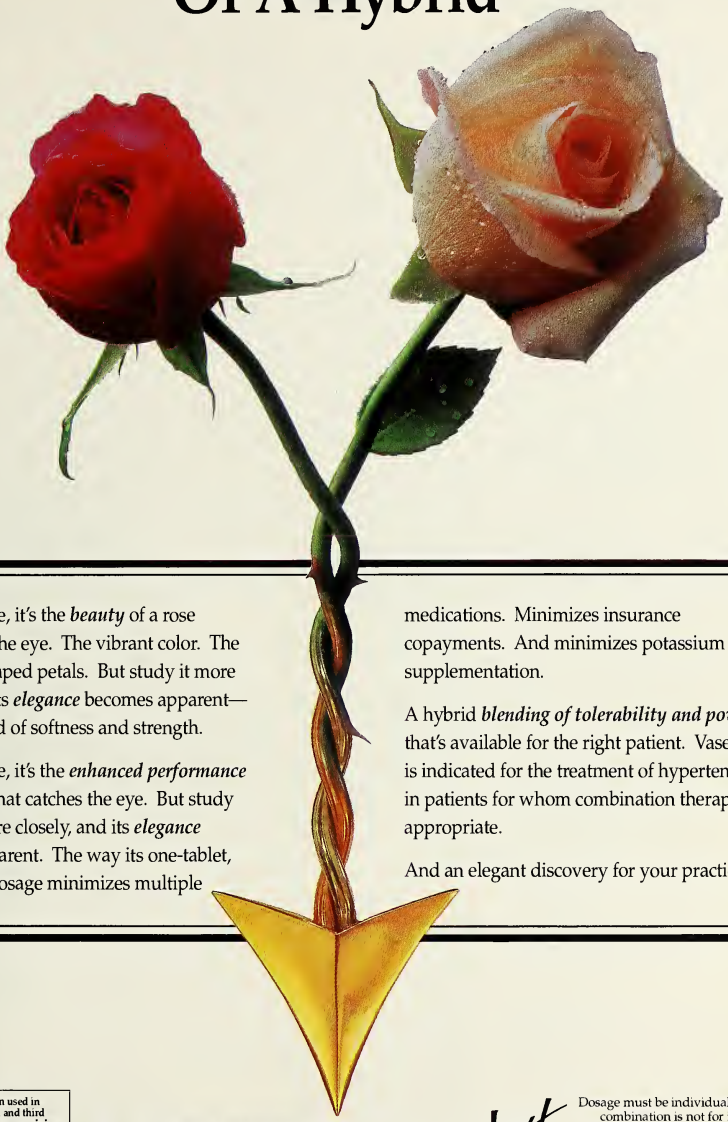
Second, analyze the ethical principles involved in the case (such as the principles of respect for autonomy, beneficence, nonmaleficence and justice). For instance, how does the principle of nonmaleficence, which obliges us not to harm others by intention or negligence, apply to the case?

Next, analyze contextual perspectives that can influence clinical decision making: (1) the patient's values, beliefs and preferences; (2) the medical goal(s) applicable to the case; (3) a determination of the patient's best interests; (4) the interests of relevant third parties (e.g., family, hospital administrators, third party payors); (5) the personal values and beliefs of the physicians and other health professionals as in the case; and (6) the law.

Finally, identify the best course of action, supported with persuasive reasons. Such reasons, which can justify a determination of the "right" thing to do, usually involve some combination of applicable ethical principles and relevant contextual considerations. For me, this frequently takes the form of advice I may give to a physician regarding an ethically problematic case. For physicians, it is, hopefully, part of the regular clinical decision-making process.

Dr. Weir is director of the program in biomedical ethics for the University of Iowa College of Medicine.

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USE IN PREGNANCY: When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC (Enalapril Maleate-Hydrochlorothiazide) should be discontinued as soon as possible. See WARNINGS, *Fetal/Neonatal Morbidity and Mortality.*

CONTRAINDICATIONS: VASERETIC is contraindicated in patients who are hypersensitive to any component of this product and in patients with a history of angioedema related to previous treatment with an angiotensin converting enzyme inhibitor. Because of the hydrochlorothiazide component, this product is contraindicated in patients with anuria or hypersensitivity to other sulfonamide-derived drugs.

WARNINGS: *General; Enalapril Maleate; Hypotension:* Excessive hypotension was rarely seen in uncomplicated hypertensive patients but is a possible consequence of enalapril use in severely salt/volume depleted persons such as those treated vigorously with diuretics or patients on dialysis.

Syncope has been reported in 1.3 percent of patients receiving VASERETIC. In patients receiving enalapril alone, the incidence of syncope is 0.5 percent. The overall incidence of syncope may be reduced by proper titration of the individual components. (See PRECAUTIONS, *Drug Interactions*, and ADVERSE REACTIONS.)

In patients with severe congestive heart failure, with or without associated renal insufficiency, excessive hypotension has been observed and may be associated with oliguria and/or progressive azotemia, and rarely with acute renal failure and/or death. Because of the potential fall in blood pressure in these patients, therapy should be started under very close medical supervision. Such patients should be followed closely for the first two weeks of treatment and whenever the dose of enalapril and/or diuretic is increased. Similar considerations may apply to patients with ischemic heart or cerebrovascular disease, in whom an excessive fall in blood pressure could result in a myocardial infarction or cerebrovascular accident.

If hypotension occurs, the patient should be placed in the supine position and, if necessary, receive an intravenous infusion of normal saline. A transient hypotensive response is not a contraindication to further doses, which usually can be given without difficulty once the blood pressure has increased after volume expansion.

Angioedema: Angioedema of the face, extremities, lips, tongue, glottis and/or larynx has been reported in patients treated with angiotensin converting enzyme inhibitors, including enalapril. In such cases VASERETIC should be promptly discontinued and appropriate therapy and monitoring should be provided until complete and sustained resolution of signs and symptoms has occurred. In instances where swelling has been confined to the face and lips the condition has generally resolved without treatment, although antihistamines have been useful in relieving symptoms. Angioedema associated with laryngeal edema may be fatal. **Where there is involvement of the tongue, glottis or larynx, likely to cause airway obstruction, appropriate therapy, e.g., subcutaneous epinephrine solution 1:1000 (0.3 mL to 0.5 mL) and/or measures necessary to ensure a patent airway, should be promptly provided.** (see ADVERSE REACTIONS.)

Patients with a history of angioedema unrelated to ACE inhibitor therapy may be at increased risk of angioedema while receiving an ACE inhibitor (see also CONTRAINDICATIONS).

Neutropenia/Agranulocytosis: Another angiotensin converting enzyme inhibitor, captopril, has been shown to cause agranulocytosis and bone marrow depression, rarely in uncomplicated patients but more frequently in patients with renal impairment especially if they also have a collagen vascular disease. Available data from clinical trials of enalapril are insufficient to show that enalapril does not cause agranulocytosis at similar rates. Marketing experience has revealed several cases of neutropenia or agranulocytosis in which a causal relationship to enalapril cannot be excluded. Periodic monitoring of white blood cell counts in patients with collagen vascular disease and renal disease should be considered.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. Cumulative effects of the drug may develop in patients with impaired renal function.

Thiazides should be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma.

The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

Lithium generally should not be given with thiazides (see PRECAUTIONS, *Drug Interactions*).

Enalapril Maleate; Enalapril Maleate and Hydrochlorothiazide:

Pregnancy, Enalapril-Hydrochlorothiazide: There was no teratogenicity in rats given up to 90 mg/kg/day of enalapril (150 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose) or in mice given up to 30 mg/kg/day of enalapril (50 times the maximum human dose) in combination with 10 mg/kg/day of hydrochlorothiazide (2 ½ times the maximum human dose). At these doses, fetotoxicity expressed as a decrease in average fetal weight occurred in both species. No fetotoxicity occurred at lower doses; 30/10 mg/kg/day of enalapril-hydrochlorothiazide in rats and 10/10 mg/kg/day of enalapril-hydrochlorothiazide in mice.

When used in pregnancy during the second and third trimesters, ACE inhibitors can cause injury and even death to the developing fetus. When pregnancy is detected, VASERETIC should be discontinued as soon as possible. (See *Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality*, below.)

Enalapril Maleate; Fetal/Neonatal Morbidity and Mortality: ACE inhibitors can cause fetal and neonatal morbidity and death when administered to pregnant women. Several dozen cases have been reported in the world literature. When pregnancy is detected, ACE inhibitors should be discontinued as soon as possible.

The use of ACE inhibitors during the second and third trimesters of pregnancy has been associated with fetal and neonatal injury, including hypotension, neonatal skull hypoplasia, anuria, reversible or irreversible renal failure, and death. Oligohydramnios has also been reported, presumably resulting from decreased fetal renal function; oligohydramnios in this setting has been associated with fetal limb contractures, craniofacial deformation, and hypoplastic lung development. Prematurity, intrauterine growth retardation, and patent ductus arteriosus have also been reported, although it is not clear whether these occurrences were due to the ACE-inhibitor exposure.

These adverse effects do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. Mothers whose embryos and fetuses are exposed to ACE inhibitors only during the first trimester should be so informed. Nonetheless, when patients become pregnant, physicians should make every effort to discontinue the use of VASERETIC as soon as possible.

Rarely (probably less often than once in every thousand pregnancies), no alternative to ACE inhibitors will be found. In these rare cases, the mothers should be apprised of the potential hazards to their fetuses, and serial ultrasound examinations should be performed to assess the intraamniotic environment.

If oligohydramnios is observed, VASERETIC should be discontinued unless it is considered lifesaving for the mother. Contraction stress testing (CST), a non-stress test (NST), or biophysical profiling (BPP) may be appropriate, depending upon the week of pregnancy. Patients and physicians should be aware, however, that oligohydramnios may not appear until after the fetus has sustained irreversible injury.

Infants with histories of *in utero* exposure to ACE inhibitors should be closely observed for hypotension, oliguria, and hyperkalemia. If oliguria occurs, attention should be directed toward support of blood pressure and renal perfusion. Exchange transfusion or dialysis may be required as means of reversing hypotension and/or substituting for disordered renal function. Enalapril, which crosses the placenta, has been removed from neonatal circulation by peritoneal dialysis with some clinical benefit, and theoretically may be removed by exchange transfusion, although there is no experience with the latter procedure.

No teratogenic effects of enalapril were seen in studies of pregnant rats, mice, and rabbits. On a mg/kg basis, the doses used were up to 333 times (in rats), and 50 times (in rabbits) the maximum recommended human dose.

Hydrochlorothiazide; Teratogenic Effects: Reproduction studies in the rabbit, the mouse and the rat at doses up to 100 mg/kg/day (50 times the human dose) showed no evidence of external abnormalities of the fetus due to hydrochlorothiazide. Hydrochlorothiazide given in a two-litter study in rats at doses of 4 - 5.6 mg/kg/day (approximately 1 - 2 times the usual daily human dose) did not impair fertility or produce birth abnormalities in the offspring. Thiazides cross the placental barrier and appear in cord blood.

Nonteratogenic Effects: These may include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

PRECAUTIONS: *General; Enalapril Maleate; Impaired Renal Function:* As a consequence of inhibiting the renin-angiotensin-aldosterone system, changes in renal function may be anticipated in susceptible individuals. In patients with severe congestive heart failure whose renal function may depend on the activity of the renin-angiotensin-aldosterone system, treatment with angiotensin converting enzyme inhibitors, including enalapril, may be associated with oliguria and/or progressive azotemia and rarely with acute renal failure and/or death.

In clinical studies in hypertensive patients with unilateral or bilateral renal artery stenosis, increases in blood urea nitrogen and serum creatinine were observed in 20 percent of patients. These increases were almost always reversible upon discontinuation of enalapril and/or diuretic therapy. In such patients renal function should be monitored during the first few weeks of therapy.

Some patients with hypertension or heart failure with no apparent preexisting renal vascular disease have developed increases in blood urea and serum creatinine, usually minor and transient, especially when enalapril has been given concomitantly with a diuretic. This is more likely to occur in patients with pre-existing renal impairment. Dosage reduction of enalapril and/or discontinuation of the diuretic may be required.

Evaluation of the hypertensive patient should always include assessment of renal function.

Hemodialysis Patients: Anaphylactoid reactions have been reported in patients dialyzed with high-flux membranes (e.g., AN 69*) and treated concomitantly with an ACE inhibitor. In these patients consideration should be given to using a different type of dialysis membrane or a different class of antihypertensive agent.

Hyperkalemia: Elevated serum potassium (greater than 5.7 mEq/L) was observed in approximately one percent of hypertensive patients in clinical trials treated with enalapril alone. In most cases these were isolated values which resolved despite continued therapy, although hyperkalemia was a cause of discontinuation of therapy in 0.28 percent of hypertensive patients. Hyperkalemia was less frequent (approximately 0.1 percent) in patients treated with enalapril plus hydrochlorothiazide. Risk factors for the development of hyperkalemia include renal insufficiency, diabetes mellitus, and the concomitant use of potassium-sparing diuretics, potassium supplements and/or potassium-containing salt substitutes, which should be used cautiously, if at all, with enalapril (See *Drug Interactions.*)

Cough: Cough has been reported with the use of ACE inhibitors. Characteristically, the cough is nonproductive, persistent and resolves after discontinuation of therapy. ACE-inhibitor-induced cough should be considered as part of the differential diagnosis of cough.

Surgery/Anesthesia: In patients undergoing major surgery or during anesthesia with agents that produce hypotension, enalapril may block angiotensin II formation secondary to compensatory renin release. If hypotension occurs and is considered to be due to this mechanism, it can be corrected by volume expansion.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Warning signs or symptoms of fluid and electrolyte imbalance, irrespective of cause, include dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, confusion, seizures, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or after prolonged therapy. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia may cause cardiac arrhythmia and may also sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Because enalapril reduces the production of aldosterone, concomitant therapy with enalapril attenuates the diuretic-induced potassium loss (see *Drug Interactions, Agents Increasing Serum Potassium*).

Although any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease), chloride replacement may be required in the treatment of metabolic alkalosis.

Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

In diabetic patients dosage adjustments of insulin or oral hypoglycemic agents may be required. Hyperglycemia may occur with thiazide diuretics. Thus latent diabetes mellitus may become manifest during thiazide therapy.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient.

If progressive renal impairment becomes evident consider withholding or discontinuing diuretic therapy.

Thiazides have been shown to increase the urinary excretion of magnesium; this may result in hypomagnesemia.

Thiazides may decrease urinary calcium excretion. Thiazides may cause intermittent and slight elevation of serum calcium in the absence of known disorders of calcium metabolism. Marked hypercalcemia may be evidence of hidden hyperparathyroidism. Thiazides should be discontinued before carrying out tests for parathyroid function.

Increases in cholesterol and triglyceride levels may be associated with thiazide diuretic therapy.

Information for Patients; Angioedema: Angioedema, including laryngeal edema, may occur especially following the first dose of enalapril. Patients should be so advised and told to report immediately any signs or symptoms suggesting angioedema (swelling of face, extremities, eyes, lips, tongue, difficulty in swallowing or breathing) and to take no more drug until they have consulted with the prescribing physician.

Hypotension: Patients should be cautioned to report lightheadedness especially during the first few days of therapy. If actual syncope occurs, the patients should be told to discontinue the drug until they have consulted with the prescribing physician.

All patients should be cautioned that excessive perspiration and dehydration may lead to an excessive fall in blood pressure because of reduction in fluid volume. Other causes of volume depletion such as vomiting or diarrhea may also lead to a fall in blood pressure; patients should be advised to consult with the physician.

Hyperkalemia: Patients should be told not to use salt substitutes containing potassium without consulting their physician.

Neutropenia: Patients should be told to report promptly any indication of infection (e.g. sore throat, fever) which may be a sign of neutropenia.

Pregnancy: Female patients of childbearing age should be told about the consequences of second- and third-trimester exposure to ACE inhibitors, and they should also be told that these consequences do not appear to have resulted from intrauterine ACE-inhibitor exposure that has been limited to the first trimester. These patients should be asked to report pregnancies to their physicians as soon as possible.

NOTE: As with many other drugs, certain advice to patients being treated with VASERETIC is warranted. This information is intended to aid in the safe and effective use of this medication. It is not a disclosure of all possible adverse or intended effects.

Drug Interactions; Enalapril Maleate: Hypotension—Patients on Diuretic Therapy: Patients on diuretics and especially those in whom diuretic therapy was recently instituted, may occasionally experience an excessive reduction of blood pressure after initiation of therapy with enalapril. The possibility of hypotensive effects with enalapril can be minimized by either discontinuing the diuretic or increasing the salt intake prior to initiation of treatment with enalapril. If it is necessary to continue the diuretic, provide medical supervision for at least two hours and until blood pressure has stabilized for at least an additional hour. (See WARNINGS.)

Agents Causing Renin Release: The antihypertensive effect of enalapril is augmented by antihypertensive agents that cause renin release (e.g., diuretics).

Other Cardiovascular Agents: Enalapril has been used concomitantly with beta adrenergic-blocking agents, methyldopa, nitrates, calcium-blocking agents, hydralazine and prazosin without evidence of clinically significant adverse interactions.

Agents Increasing Serum Potassium: Enalapril attenuates diuretic-induced potassium loss. Potassium-sparing diuretics (e.g., spironolactone, triamterene, or amiloride), potassium supplements, or potassium-containing salt substitutes may lead to significant increases in serum potassium. Therefore, if concomitant use of these agents is indicated because of demonstrated hypokalemia they should be used with caution and with frequent monitoring of serum potassium.

Lithium: Lithium toxicity has been reported in patients receiving lithium concomitantly with drugs which cause elimination of sodium, including ACE inhibitors. A few cases of lithium toxicity have been reported in patients receiving concomitant enalapril and lithium and were reversible upon discontinuation of both drugs. It is recommended that serum lithium levels be monitored frequently if enalapril is administered concomitantly with lithium.

Hydrochlorothiazide; When administered concurrently the following drugs may interact with thiazide diuretics:

Alcohol, barbiturates, or narcotics—potentiation of orthostatic hypotension may occur.

Antidiabetic drugs (oral agents and insulin)—dosage adjustment of the antidiabetic drug may be required.

Other antihypertensive drugs—additive effect or potentiation.

Cholestyramine and colestipol resins—Absorption of hydrochlorothiazide is impaired in the presence of anionic exchange resins. Single doses of either cholestyramine or colestipol resins bind the hydrochlorothiazide and reduce its absorption from the gastrointestinal tract by up to 85 and 43 percent, respectively.

Corticosteroids, ACTH—intensified electrolyte depletion, particularly hypokalemia.

Pressor amines (e.g., norepinephrine)—possible decreased response to pressor amines but not sufficient to preclude their use.

Skeletal muscle relaxants, nondepolarizing (e.g., tubocurarine)—possible increased responsiveness to the muscle relaxant.

Lithium—should not generally be given with diuretics. Diuretic agents reduce the renal clearance of lithium and add a high risk of lithium toxicity. Refer to the package insert for lithium preparations before use of such preparations with VASERETIC.

Non-steroidal Anti-inflammatory Drugs—In some patients, the administration of a non-steroidal anti-inflammatory agent can reduce the diuretic, natriuretic, and antihypertensive effects of loop, potassium-sparing and thiazide diuretics. Therefore, when VASERETIC and non-steroidal anti-inflammatory agents are used concomitantly, the patient should be observed closely to determine if the desired effect of the diuretic is obtained.

Carcinogenesis, Mutagenesis, Impairment of Fertility. Enalapril in combination with hydrochlorothiazide was not mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril-hydrochlorothiazide did not produce DNA single strand breaks in an *in vitro* alkaline elution assay in rat hepatocytes or chromosomal aberrations in an *in vivo* mouse

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bone marrow assay.

Enalapril Maleate: There was no evidence of a tumorigenic effect when enalapril was administered for 106 weeks to rats at doses up to 90 mg/kg/day (150 times* the maximum daily human dose). Enalapril has also been administered for 94 weeks to male and female mice at doses up to 90 and 180 mg/kg/day, respectively, (150 and 300 times* the maximum daily dose for humans) and showed no evidence of carcinogenicity.

Neither enalapril maleate nor the active diacid was mutagenic in the Ames microbial mutagen test with or without metabolic activation. Enalapril was also negative in the following genotoxicity studies: rec-assay, reverse mutation assay with *E. coli*, sister chromatid exchange with cultured mammalian cells, and the micronucleus test with mice, as well as in an *in vivo* cytogenic study using mouse bone marrow.

There were no adverse effects on reproductive performance in male and female rats treated with 10 to 90 mg/kg/day of enalapril.

Hydrochlorothiazide: Two-year feeding studies in mice and rats conducted under the auspices of the National Toxicology Program (NTP) uncovered no evidence of a carcinogenic potential of hydrochlorothiazide in female mice (at doses of up to approximately 600 mg/kg/day) or in male and female rats (at doses of up to approximately 100 mg/kg/day). The NTP, however, found equivocal evidence for hepatocarcinogenicity in male mice.

Hydrochlorothiazide was not genotoxic *in vitro* in the Ames mutagenicity assay of *Salmonella typhimurium* strains TA 98, TA 100, TA 1535, TA 1537, and TA 1538 and in the Chinese Hamster Ovary (CHO) test for chromosomal aberrations, or *in vivo* in assays using mouse germinal cell chromosomes, Chinese hamster bone marrow chromosomes, and the *Drosophila* sex-linked recessive lethal trait gene. Positive test results were obtained only in the *in vitro* CHO Sister Chromatid Exchange (clastogenicity) and in the Mouse Lymphoma Cell (mutagenicity) assays, using concentrations of hydrochlorothiazide from 43 to 1300 µg/mL, and in the *Aspergillus nidulans* non-disjunction assay at an unspecified concentration.

Hydrochlorothiazide had no adverse effects on the fertility of mice and rats of either sex in studies wherein these species were exposed, via their diet, to doses of up to 100 and 4 mg/kg, respectively, prior to conception and throughout gestation.

Pregnancy: Pregnancy Categories C (first trimester) *and D* (second and third trimesters). See WARNINGS, *Pregnancy, Enalapril Maleate: Fetal/Neonatal Morbidity and Mortality.*

Nursing Mothers: Enalapril and enalaprilat are detected in human milk in trace amounts. Thiazides do appear in human milk. Because of the potential for serious reactions in nursing infants from either drug, a decision should be made whether to discontinue nursing or to discontinue VASERETIC, taking into account the importance of the drug to the mother.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: VASERETIC has been evaluated for safety in more than 1500 patients, including over 300 patients treated for one year or more. In clinical trials with VASERETIC no adverse experiences peculiar to this combination drug have been observed. Adverse experiences that have occurred, have been limited to those that have been previously reported with enalapril or hydrochlorothiazide.

The most frequent clinical adverse experiences in controlled trials were: dizziness (8.6 percent), headache (5.5 percent), fatigue (3.9 percent) and cough (3.5 percent). Adverse experiences occurring in greater than two percent of patients treated with VASERETIC in controlled clinical trials were: muscle cramps (2.7 percent), nausea (2.5 percent), asthenia (2.4 percent), orthostatic effects (2.3 percent), impotence (2.2 percent), and diarrhea (2.1 percent).

Clinical adverse experiences occurring in 0.5 to 2.0 percent of patients in controlled trials included: *Body As A Whole:* Syncope, chest pain, abdominal pain; *Cardiovascular:* Orthostatic hypotension, palpitation, tachycardia; *Digestive:* Vomiting, dyspepsia, constipation, flatulence, dry mouth; *Nervous/Psychiatric:* Insomnia, nervousness, paresthesia, somnolence, vertigo; *Skin:* Pruritus, rash; *Other.* Dyspnea, gout, back pain, arthralgia, diaphoresis, decreased libido, tinnitus, urinary tract infection.

Angioedema: Angioedema has been reported in patients receiving VASERETIC (0.6 percent). Angioedema associated with laryngeal edema may be fatal. If angioedema of the face, extremities, lips, tongue, glottis and/or larynx occurs, treatment with VASERETIC should be discontinued and appropriate therapy instituted immediately. (See WARNINGS.)

Hypotension: In clinical trials, adverse effects relating to hypotension occurred as follows: hypotension (0.9 percent), orthostatic hypotension (1.5 percent), other orthostatic effects (2.3 percent). In addition syncope occurred in 1.3 percent of patients. (See WARNINGS.)

Cough: See PRECAUTIONS, *Cough.*

Clinical Laboratory Test Findings, Serum Electrolytes: See PRECAUTIONS.

Creatinine, Blood Urea Nitrogen: In controlled clinical trials minor increases in blood urea nitrogen and serum creatinine, reversible upon discontinuation of therapy, were observed in about 0.6 percent of patients with essential hypertension treated with VASERETIC. More marked increases have been reported in other enalapril experience. Increases are more likely to occur in patients with renal artery stenosis. (See PRECAUTIONS.)

Serum Uric Acid, Glucose, Magnesium, and Calcium: See PRECAUTIONS.

Hemoglobin and Hematocrit: Small decreases in hemoglobin and hematocrit (mean decreases of approximately 0.3 g percent and 1.0 vol percent, respectively) occur frequently in hypertensive patients treated with VASERETIC but are rarely of clinical importance unless another cause of anemia coexists. In clinical trials, less than 0.1 percent of patients discontinued therapy due to anemia.

Liver Function Tests: Rarely, elevations of liver enzymes and/or serum bilirubin have occurred.

Other adverse reactions that have been reported with the individual components are listed below and, within each category, are in order of decreasing severity.

Enalapril Maleate—Enalapril has been evaluated for safety in more than 10,000 patients. In clinical trials adverse reactions which occurred with enalapril were also seen with VASERETIC. However, since enalapril has been marketed, the following adverse reactions have been reported: *Body As A Whole:* Anaphylactoid reactions (see PRECAUTIONS, *Hemodialysis Patients*); *Cardiovascular:* Cardiac arrest; myocardial infarction or cerebrovascular accident, possibly secondary to excessive hypotension in high risk patients (see WARNINGS, *Hypotension*), pulmonary embolism and infarction; pulmonary edema; rhythm disturbances including atrial tachycardia and bradycardia; atrial fibrillation; hypotension; angina pectoris; *Digestive:* Ileus, pancreatitis, hepatic failure, hepatitis (hepatocellular [proven on rechallenge] or cholestatic jaundice), melena, anorexia, glossitis, stomatitis, dry mouth; *Hematologic:* Rare cases of neutropenia, thrombocytopenia and bone marrow depression. Hemolytic anemia, including cases of hemolysis in patients with G-6-PD deficiency, has been reported; a causal relationship to enalapril has not been established; *Nervous System/Psychiatric:* Depression, confusion, ataxia, peripheral neuropathy (e.g., paresthesia, dysesthesia); *Urogenital:* Renal failure, oliguria, renal dysfunction (see PRECAUTIONS), flank pain, gynecomastia; *Respiratory:* Pulmonary infiltrates, bronchospasm, pneumonia, bronchitis, rhinorrhea, sore throat and hoarseness, asthma, upper respiratory infection; *Skin:* Exfoliative dermatitis, toxic epidermal necrolysis, Stevens-Johnson syndrome, herpes zoster, erythema multiforme, urticaria, pemphigus, alopecia, flushing, photosensitivity; *Special Senses:* Blurred vision, taste alteration, anosmia, conjunctivitis, dry eyes, tearing.

Miscellaneous: A symptom complex has been reported which may include a positive ANA, an elevated erythrocyte sedimentation rate, arthralgia/arthritis, myalgia/myositis, fever, serositis, vasculitis, leukocytosis, eosinophilia, photosensitivity, rash and other dermatologic manifestations.

Fetal/Neonatal Morbidity and Mortality: See WARNINGS, *Pregnancy, Enalapril Maleate, Fetal/Neonatal Morbidity and Mortality.*

Hydrochlorothiazide—Body as a Whole: Weakness; *Digestive:* Pancreatitis, jaundice (intrahepatic cholestatic jaundice), sialadenitis, cramping, gastric irritation, anorexia; *Hematologic:* Aplastic anemia, agranulocytosis, leukopenia, hemolytic anemia, thrombocytopenia; *Hypersensitivity:* Purpura, photosensitivity, urticaria, necrotizing angiitis (vasculitis and cutaneous vasculitis), fever, respiratory distress including pneumonitis and pulmonary edema, anaphylactic reactions; *Musculoskeletal:* Muscle spasm; *Nervous System/Psychiatric:* Restlessness; *Renal:* Renal failure, renal dysfunction, interstitial nephritis (see WARNINGS); *Skin:* Erythema multiforme including Stevens-Johnson syndrome, exfoliative dermatitis including toxic epidermal necrolysis, alopecia; *Special Senses:* Transient blurred vision, xanthopsia.

* Based on patient weight of 50 kg.

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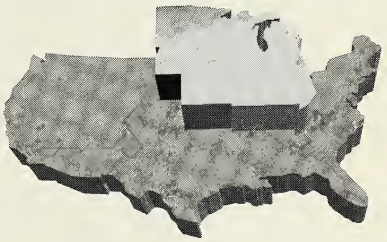
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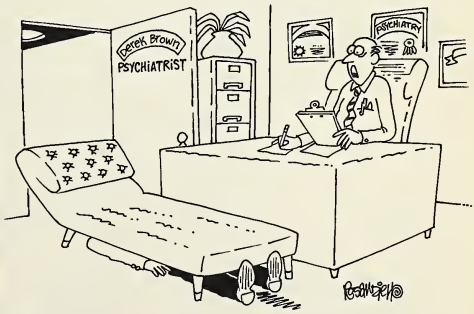
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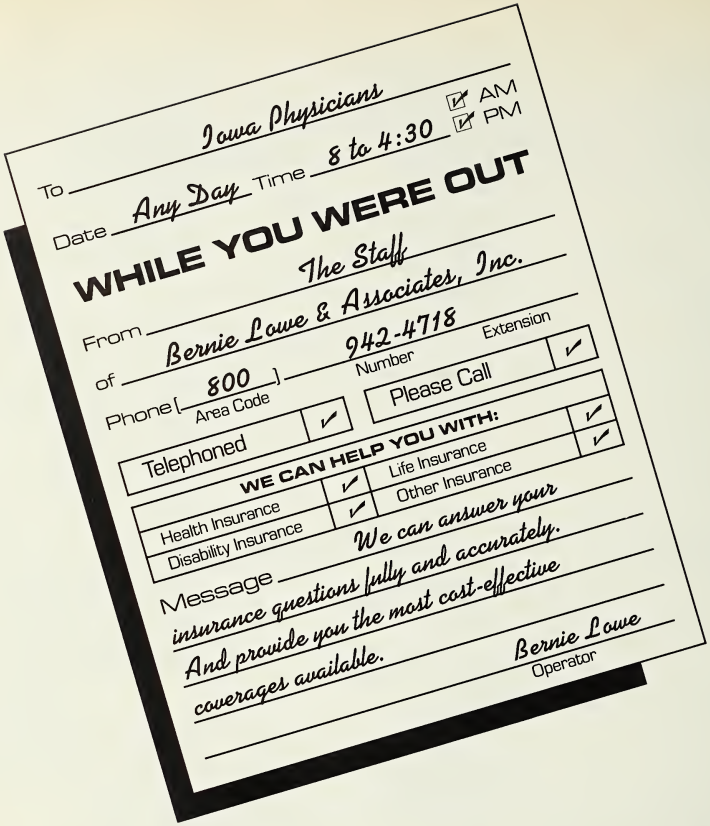
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John Anderson, M.D.

BME has important job

RECENTLY, THE IOWA BOARD of Medical Examiners ranked second in the country in disciplinary performance. The BME has ranked in the top 10 for the last decade or so. This is a record of which the BME is very proud. It is the result of a lot of hard work and dedication by both the Board and its staff.

The Board is appointed by the Governor and must be balanced in regards to gender, political affiliation and geography. The BME consists of five M.D.s, two D.O.s and three lay people who add a different and needed dimension. The Board is assisted by 12 investigators, a secretarial staff and Executive Director Ann Martino, who is interviewed in this issue of *IOWA MEDICINE*.

The BME's main job is licensing and disciplining physicians and their goal is to protect the citizens of Iowa. The Board meets for 1½ days every six weeks. During my tenure as a member of the BME, I weighed my reading material once and it weighed 65 pounds.

Recently when Governor Branstad began rolling back state government budgets, the BME was not immune. This resulted in delays up to 12 weeks or so in getting a license and caused complaints from doctors, hospitals and even communities waiting for a doctor. Since becoming executive director, Ann Martino has addressed this problem and the delay now is about six weeks on a "clean" application. This is the national average time for obtaining a license.

Licensing is a slow and meticulous process. The BME is required by law to contact the National Data Bank, the Federation of State Licensing Boards and the AMA Masterfile. They also contact the dean of the medical school and program chairman of the training program. The BME does this for about 5,000 licenses every year.

Having a medical license for life has produced many problems for physicians. For example, a physician may have an inactive Iowa license while living and practicing in Kansas with an active Kansas license. If the Kansas BME takes action against his or her Kansas license, the physician must notify the Iowa BME even though the Iowa license is inactive. Failure to do this lands the physician in hot water with the Iowa BME.

Obviously, licensing of physicians is an extremely important job. It makes more sense to have strict licensing to keep bad physicians out of the state than to do a lousy job of licensing, let them in and then have to go through the hassle and expense of disciplining or revoking the license.

Physicians must realize that the licensing procedure is long and allow for proper lead time when applying for a license.

In a later column, I will discuss the disciplinary process of the BME.

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Marion E. Alberts, M.D.

Coping with violence

THE MEDICAL PROFESSIONALS, particularly pediatricians, often are called upon to lend their expertise in dealing with violence among children. Violence has become widespread and is a growing concern for our society. Violence surrounds us . . . in the home, the school, on the streets . . . it is depicted much too frequently on television, as well as in the printed media. Violence is not new. Some of Charles Dickens writings depict violence towards children. A saying has come from these writings . . . a child will be "given the dickens" for committing unbecoming behavior.

Why have violence and various forms of aggressive behavior become a national societal problem? Is television responsible? Have more aggressive attitudes within sports been a factor? Are crowded housing facilities responsible? Have parents in many instances abdicated their responsibilities? Is family life structured differently from five decades ago? Are children given too much freedom and not enough responsibility?

We continue to ask similar questions. There is no one answer, but it is certain something is rotten in our society and it is a national (as well as international) disgrace.

Violence among children presents in various ways. Some children demonstrate antisocial behavior early in life in the form of simple temper tantrums. The novice parent becomes frustrated. The child may learn from this experience that a temper tantrum (violence) is a valuable tool to control various situations. The knowledgeable parents know that such behavior is not to be tolerated and through non-violent means teaches the child otherwise. Uncontrolled violent behavior is habit forming. One act leads to others. Eventually the individual becomes a youth with misdirected attitudes toward society.

Too many children in our nation have few opportunities to learn right from wrong. Broken homes, unreliable guidance from adults, the irresponsible promotion of antisocial behavior by various media and the lack of participation by children in wholesome activities (church groups, youth enrichment activities) are all factors.

The medical profession has conquered numerous fatal and disabling illnesses; but, so far have no cure for youth violence. There is a cure in which we can participate — we must be more active politically. Social behavior is a problem of the political scientists. All citizens must demand that politicians and lawmakers develop sensible and effective solutions to this national disgrace. Talk is cheap and action may be expensive, but isn't the expense astronomic already? Now is the time for our lawmakers to face reality and devise solutions to the ever-increasing plague which encompasses our communities.

Andy and David . . . A personal look at two special needs' children

Quality of life is the main concern for the parents of a child with cerebral palsy and multiple health problems. For another set of parents, Fragile X means coping with a child living in a man's body.

Andy

Christine Clark
Managing editor

ONE OF THE FIRST THINGS YOU NOTICE about Andy is the sweetness of his smile. It's a smile that tells you he hasn't learned how to hide his emotions or hold things back. You also notice that, like thousands of 12-year-old boys, Andy loves school, idolizes Michael Jordan and dreams of having a Harley Davidson motorcycle.

But there his resemblance to most other kids ends, for Andy has cerebral palsy. He is moderately retarded, lives in a motorized wheelchair and is unable to speak because of his physical handicap. He has a host of medical problems, including a life-threatening inability to swallow.

Goal is life quality

"Fluid is aspirated into his lungs and he can get into a severe respiratory situation at any time," explains Andy's mother Shelley Ackermann, a social worker at Blank Childrens Hospital. "We've been told several times that Andy wouldn't survive much longer, and our main goal for him is quality of life."

Shelley and her husband Mark, a veterinarian, are the kind of parents a kid like Andy should have. They're sensitive to all his needs, educated about his condition and very involved in his life. When there's a decision to make, they make it together based on the best information available.

"If we have trouble making a decision, we always default to what is the best choice for Andy," says Shelley. "Sometimes this means sacrifice."

The Ackermanns, who live in Ankeny, cared for Andy at home for the first three years of his life but finally made what they say was an extremely difficult decision. After much soul-searching and discussions with other parents of handicapped kids, they placed three-year-old Andy in the Children's Habilitation Center (CHC) in Johnston.

"My wife and I were both full time ISU students and overtime parents for Andrew. It took nearly six months after Andy went to CHC to realize how consumed we had become with his care," says Mark Ackermann. "We soon learned how Andy could truly benefit from having a fresh set of caregivers every eight hours. Also, he gets to participate in recreational therapy, outings and mainstreaming into real school classes."

Andy's diagnosis of cerebral palsy came within three days after his birth, but this

(Continued page 402)

David

Davi Mondt Lowman, R.N.
Jackson, Minnesota

DAVID IS MY SECOND SON. He's nearly 17 years old and he is a Fragile X kid. Fragile X is an inherited gene anomaly manifesting itself in a wide range of retardation, mostly in males. It can be transferred by non-affected parents and usually skips a generation. It is thought to be the cause of up to 50% of all mental retardation.

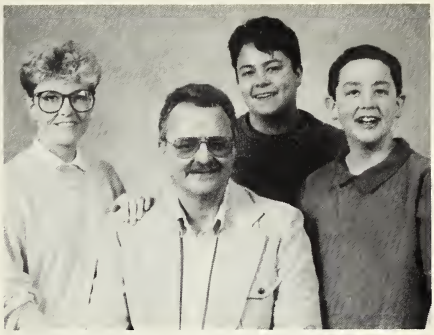
On the surface, David is like most kids. He is nice looking and listens to music through headphones. He has an extensive vocabulary, an exact memory and a great sense of humor. In these areas, there are no differences between David and his older brother, Jonathan.

However, this six foot, 200-pound boy still needs help cleaning himself after a bowel movement. He cannot be left alone because he might, at best, feel frightened or, at worst, start a fire. He memorizes songs, but is incapable of dialing 911. He earned a varisty letter as manager of the football team but sleeps with a Mickey Mouse doll. He was 14 before he was able to shower alone, and then only with me or my husband standing outside the shower.

Handicap was a mystery

I am a registered nurse and when David was six months old I noticed that the "Y" formed by his bottom and thighs was unusually high and he was extremely limber. His hips were x-rayed with negative results. David had almost continuous ear infections. He was very thin with long limbs, a large forehead and prominent ears. He also had large testicles and large hands with non-tapering fingers. Though I had no way of knowing at the time, these are features of Fragile X. At nine months of age, David was unable to sit up, had a bluish tint to the sclera of his eyes and still demonstrated extreme joint mobility.

He was seen by a specialist who ruled out osteogenesis imperfecta. His diagnosis was "delayed motor development." When he was three, I took him to a genetics clinic. The experts there ruled out retardation and said he "needed time to develop." When he was five, he was tested in Denver, Colorado by doctors who recommended institutional placement. During all this, I knew David was handicapped but not why.



David (far right) poses with his brother Jonathan and his parents Davi and Galen Lowman.

When David felt frustrated, he would drop to the floor, pull his hair or bang his head on the wall. We began home speech and behavioral therapy which helped him learn how to communicate and control his behavior.

My nephew Jay, who was David's age, was also "slow" but we didn't know why. In 1984, Jay died at age seven from idiopathic cardiomyopathy. During Jay's illness, we were told tests had revealed Fragile X. Our entire family was tested at the University of Iowa and then at UCLA. In the midst of the tragedy of my nephew's death, it was a relief to finally know the cause of David's handicap.

Ritual means security

We try to keep a consistent daily schedule for David because rituals give him a sense of security. David has learned the difference between right and wrong and what is socially acceptable.

When I attend the Special Olympics, I feel lucky to have David because there are many children with severe mental and physical handicaps. However, it's difficult to feel "lucky" when I remember David will be a child forever.

(Continued page 403)

Ms. Lowman, a native of Iowa, is director of nursing at the Windom Area Hospital in Windom, Minnesota.

Andy *(continued)*

wasn't much help to his devastated parents. Cerebral palsy, say the Ackermanns, encompasses such a broad range of physical and mental handicaps that the diagnosis has little meaning.

"We had this label for Andy, but it was tough to deal with because we still didn't know what to expect," explains Shelley. "There are no comparative guideposts for his development or lifespan."

Problem assessing Andy's mental abilities

At first, doctors told the Ackermanns their son was profoundly retarded, but that diagnosis was reclassified to moderately retarded just a few years ago.

"There are plenty of tests to measure physical progress but there aren't good tests to measure a child like Andy mentally," explains Shelley. "He started to take one I.Q. test but he missed three questions and they wouldn't let him complete the test."

Later in his life, Andy's parents and others began to realize his mental abilities had been underestimated. He has invented his own sign language and can converse by using a computerized "Touch Talker." He attends special education classes in Ankeny, where he studies daily living skills and modified industrial arts and has even made a best friend. Andy's parents believe strongly that this is the best life for him and they are, in the words of one doctor, "the experts when it comes to your son."

"It was great to hear the physician say that," comments Shelley. "It's so important to feel that the doctor is honest and understands. I don't want us or Andy to be categorized."

"Some of our best allies have been Andy's physicians," adds Mark.



Andy (foreground) with his parents Mark and Shelley Ackermann.

Genetic counseling

Shelley and Mark also have two daughters ages two and seven but consulted with a genetics expert at the University of Iowa before having other children.

"In genetic counseling, they told us the chances were minute that we'd have another child with cerebral palsy," comments Shelley. "Of course, if Andy lived at home there is no way we could have had other children."

Andy is a proud big brother, and loves to hear about his sisters' activities.

"We all see Andy several times a week and the girls just love to go along," relates Mark. "Sometimes they bring friends who also learn about handicapped kids."

The Ackermanns say they have considered leaving Iowa for career reasons but have always abandoned the idea. They have been unable to find a place for Andy that is as good as the Children's Habilitation Center.

"We've stayed in Iowa despite the lucrative job opportunities elsewhere because Andy has a life here, not just an existence," concludes Mark. "It's difficult to explain, but Andy, our family and CHC—it's a way of life for all of us."

Shelley agrees wholeheartedly with her husband that they have done what is best for Andy.

"Some doctors told us a permanent tracheostomy could prolong Andy's life but we decided against it because it would limit his activities," she concludes. "We focus on things that are fun and make his life better. That means keeping him active and in the

David *(continued)*

I live knowing that at any time David could be the target of some cruel statement or action. I am apprehensive about David's day-to-day life and about his future.

Though I try not to, at times I wonder what his potential would have been without the Fragile X gene which I carry. But, to deny Fragile X is to deny David.

Seeing life through a child's eyes

Fortunately, David has had minimal health problems. At present he has expressed normal curiosity and embarrassment regarding girls and sexual development. His body is experiencing all the normal changes of adolescence. Much of my apprehension is related to this area. The dichotomy of a child in a man's body presents obvious concerns.

David has given me, and others I'm sure, many opportunities to learn. I have learned much about patience and about seeing life through a child's eyes.

There are many aspects of our lives with David which are perfectly normal. David has been lucky to grow up in a family of loving, sensitive people. He's been part of a wonderful circle of supportive friends. He's also been fortunate to have been treated, as much as possible, in the same manner as the other children. There have been few differences.

We were at Special Olympics, watching and cheering, when David's brother Jonathan said, "David might be retarded in some part of his brain, but he isn't retarded in his heart."

I love both my sons the same. There are no differences.

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Ann Martino

Board goal is to pursue highest standards for physicians

The new executive director of the Iowa State Board of Medical Examiners discusses controversy generated by Board operations and outlines the Board's future goals.

How do you see your responsibilities as executive director of the BME? What is the biggest problem facing the BME?

I began my tenure in February of this year at a time when the Board was planning for the challenges ahead. As a result, my responsibilities as executive director are closely tied to the goals the Board set for the future.

First, one of the Board's major objectives is to resolve the funding problem confronting us today. Like most government agencies, the Board has been under pressure to do more with less in recent years. It is my job to find innovative ways of using scarce resources that assure the Board is able to fully discharge its duties. The staff and I are working hard to establish more effective and efficient licensure and discipline procedures.

Second, to better serve the changing health care needs of Iowans, the Board is increasing efforts to work collaboratively with others in the state's health care delivery system. I assist the Board in advising members about important issues on the health care agenda and acting as its representative in key policy debates. I also coordinate the Board's activities with other government agencies and review standing and proposed policies to ensure they are consistent with the state's long-term health care goals.

Third, the Board is committed to extending its reach outward. The more citizens know about the Board, the more effectively it will be able to carry out its regulatory duties. One of my most important responsibilities is to inform consumers, licensees and members of the health care community about the Board's regulatory functions. The staff is working on an ambitious information campaign which will culminate in production of a newsletter for licensees and a brochure about the Board's regulatory functions for widespread public distribution.

(Continued next page)

We are also making a concerted effort to reach out to members of the health care community. With comprehensive health reform on the horizon, it is critical the Board develop constructive relationships with those who share its concerns.

Last, and most importantly, the Board's primary goal is to hold Iowa physicians to the highest standards of care. My task is to assist the Board in realizing this goal and ensure that Iowans have access to quality health care today and in the future. Significant progress has been made toward this end, but there is still much to be done.

About a year ago, the BME was criticized for taking too long to process license applications. Has this situation improved?

Time required to review applications for licensure has been a focus of controversy for the Board in the past. To ensure that physicians applying for licensure are qualified and competent, an in-depth review of application materials is both necessary and appropriate. The review process is time-consuming, labor-intensive and often requires several months to complete.

For example, many of the materials applicants are required to provide must be forwarded to the Board by organizations located in other states. Some time lags are thus unavoidable. However, in licensure, as in all other agency operations, there is room for improvement. The Board is now exploring various strategies for expediting the application process that preserve the important quality controls built into the system.

First, the installation of a computer-based communications network in the Board's office has simplified application materials and made it easier to verify information relating to applicant credentials. Second, the staff has been reorganized to assure that sufficient personnel are available to handle the licensure work load and one investigator is now allocated to licensure full-time. We have also requested approval to hire an administrative aide to serve as a liaison to the directors of residency programs, health facilities and prospective candidates.

Third, the staff now gives candidates information about the amount of time required to process applications when they make initial contact with the Board's office. Written notice is also sent to physicians apprising them of the status of their applications at regular intervals.

The net effect of these changes is that the Board receives far fewer complaints and the integrity of the review process has been preserved. The Board is confident that physicians issued licenses today are capable of providing the high quality of care.

Recently, it was revealed that Iowa ranks second in the country in the proportion of serious disciplinary actions against doctors. In a *Des Moines Register* article, you commented that this ranking is a "two-edged sword." What did you mean?

During the last several years, the Board's disciplinary performance has been praised as among the best in the nation by the Public Citizen Health Research Group (PCHRG)—a public advocacy group headed by Dr. Sidney Wolfe, M.D. The PCHRG annual report evaluates and ranks each board in terms of the number of formal disciplinary actions per practicing licensees. Although the PCHRG report includes a brief evaluation of every board's overall performance, the rankings tend to receive the most attention from media organizations and public officials.

In the PCHRG report for 1991, the Iowa Board was ranked fourth of 54 evaluated; in 1992, the Board rose to second in the nation in the rankings. Although the Board is proud of its disciplinary performance, both members and staff agree that rankings of any kind should be viewed with caution. Indeed, the disciplinary rankings focus on only one of several complex regulatory function state medical boards perform and then in a narrow time frame. Despite this fact, they are frequently used by state officials as the basis for policy decisions with long-term consequences for medical boards and the citizens they protect. Moreover, the state-by-state comparisons that inevitably result belie the spirit of cooperation state medical regulatory authorities nationwide have worked so hard to achieve.

The Board is confident that its exemplary disciplinary performance has not come at the expense of its other functions or its long-standing commitment to serve Iowans. Irrespective of where it ranks in the future, the Board intends to pursue its regulatory responsibilities with equal rigor and vigor. It is our hope all other state medical boards will do the same.

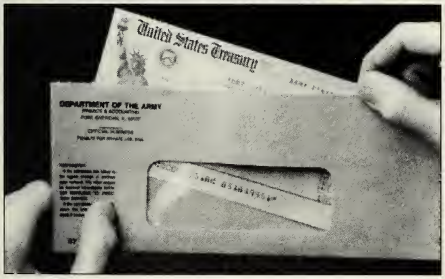
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Romania trips planned for February and June

Dear Editor:
I am writing about an opportunity for a physician to help improve medical care in Romania. A small organization, Humanity United in Giving (HUG) has "adopted" Alexandria, a city of 24,000 with an orphanage and a 750-bed district general hospital. Since 1991 HUG has been working to improve quality of care through hands-on help by doctors, nurses, physical therapists, pharmacists, teachers, mothers and grandmothers. HUG has also delivered large amounts of supplies and medicine.

HUG has made several two-week visits yearly since 1991 with 15-20 volunteers in an effort to give humanitarian aid and educate care givers. The next two trips are planned for February 17–March 5 and June 16–July 2 and all volunteers are welcome, but a physician is especially needed.

Volunteers pay their own way. Cost including airfare is about $1,500. As the physician on the first volunteer group and one who has been to Ghana, West Africa on three, two-month missions, I recommend it highly. I particularly appeal to retirees and the semi-retired who would like to use their medical skills to help people.

If you are interested please contact Judy Broom, 3009 Galaxie Road, Garland, Texas 75044; 214/495-4080. Feel free to call me for insight.—*Gene Egli, M.D., Fairfield, Iowa.*

IMSA provides Youth Support Cards

The Iowa Medical Society Alliance has spearheaded a project to support the health and well-being of our youth. The Youth Support Cards are billfold-size cards listing toll-free telephone numbers which provide crisis counseling or information. A reproduction of the card appears below.

The Alliance hopes to have these cards distributed to every junior high and high school in Iowa.



Toll Free Youth Support Numbers

• Adolescent Suicide	1-800-621-4000
• AIDS Information	1-800-342-2437
• Al-Anon & Alateen	1-800-356-9996
• Boystown Nat'l Hotline	1-800-448-3000
• Child Abuse Hotline	1-800-422-4453
• Covenant House 9 Line	1-800-999-9999
• Food Addiction	1-800-872-0088
• Foundation II Crisis Center	1-800-332-4224
• Homework Hotline	1-800-728-6450
• Iowa Teen Health Line 4:00 to 8:00 p.m. Mon-Fri	1-800-443-8336
• Nat'l Runaway Switchboard	1-800-621-4000
• Sexually Transmitted Diseases 9:00 to 12:00 a.m. Mon-Fri	1-800-227-8922

TMS - TMSA

First freestanding hospice inpatient unit established in Iowa

Inpatient care in a quiet setting enhances continuity and quality of care for hospice patients.

Ann MacGregor
Mason City

IN MEDIEVAL TIMES, the term "hospice" designated a place where a weary traveler could find respite and shelter.

Today, hospice remains a place for comfort and respite. The "traveler" and a family, sharing the final journey of life, find rest and relief in hospice care.

The philosophy of modern hospice stems from ideas and convictions of an English physician, Dame Cicely Saunders who founded the first modern hospice care program in London in 1967. St. Christopher's Hospice is the model for most institutional hospice programs in England, Canada and the United States.

In 1982, Hospice of North Iowa began serving terminally ill patients and their families. Since then, satellite offices have been established in Hampton, Forest City and Charles City. In this network of regional units, Hospice of North Iowa serves between 70-80 patients daily.

Hospice care strives to support the physical and spiritual needs of the patient and family. Doctors, nurses, grief specialists, social workers, clergy and volunteers form an interdisciplinary team specially trained to control pain and symptoms and give counsel, support and solace.

Ann MacGregor is executive director of Hospice of North Iowa.

Staff and volunteers associated with Hospice of North Iowa believe care at home is the choice of most patients who face a limited life expectancy. The hospice interdisciplinary team focuses on its mission to support patients in this wish . . . to remain at home, in control and comfortable . . . as long as there is life.

At times, however, home care must be supplemented by short-term care in an inpatient setting. Strategic planning by the hospice staff and board of directors identified the need to provide appropriate continuity of care when a patient is transferred from home to a facility setting. Thorough review and study led to development of a place that can provide such continuity. Inpatient care in a freestanding hospice inpatient unit appeared to be the answer.

A community site selection committee concluded that a building (not hospital based) with space for inpatient care in a quiet setting answered the perceived need. In addition, the committee recommended inclusion of space for administrative and home care staff. An historic home and carriage house, located on a residential, tree-lined street, seemed to be the perfect site.

Grand opening and dedication of the Hospice of North Iowa Center took place in May 1992 . . . almost four years from beginning of the effort. Gifts from generous individuals, businesses, organizations and foundations were key to reaching our goal.

(Continued next page)

The Hospice Center is headquarters for all patient care and administrative activities. Patients with special needs may enter the six-bed unit when it is deemed appropriate.

From its inception, Hospice of North Iowa has been and will remain a home care program. Our inpatient unit enhances the quality of life for those patients who cannot remain at home. Its hallmark remains short-term care in a home-like atmosphere.

In the hospice inpatient unit, the following levels of palliative care are provided:

Pain and symptom management—Professional staff provides adjustment of therapy, careful monitoring and continuity of hospice care. Our goal is to stabilize the patient for return to the home setting.

Final care—For patients unable to remain at home during the final days of life, the unit can provide a caring environment for a dignified and comfortable death.

Respite care—Vital continuing care for the patient so the primary caregiver may have relief and rest.

Physician services

Physician services to patients in the unit are provided in several ways. Some attending physicians follow their patients directly. Others transfer management of inpatient care to our medical directors, Drs. Mark Johnson and Susan Urbatsch. Daily rounds are required when a patient is admitted for pain and symptom management.

Admitting criteria, patient care guidelines and treatment parameters have been established by the staff and medical directors. Attending physicians, as well as the medical directors, must approve each admission. Since this is a palliative care unit, patients are required to sign a DNR consent prior to admission.

The completion of the Hospice Center has helped us address special needs identified during our decade of service to terminally ill patients and their loved ones. It has permitted us to establish an additional component that enhances continuity and quality of care.

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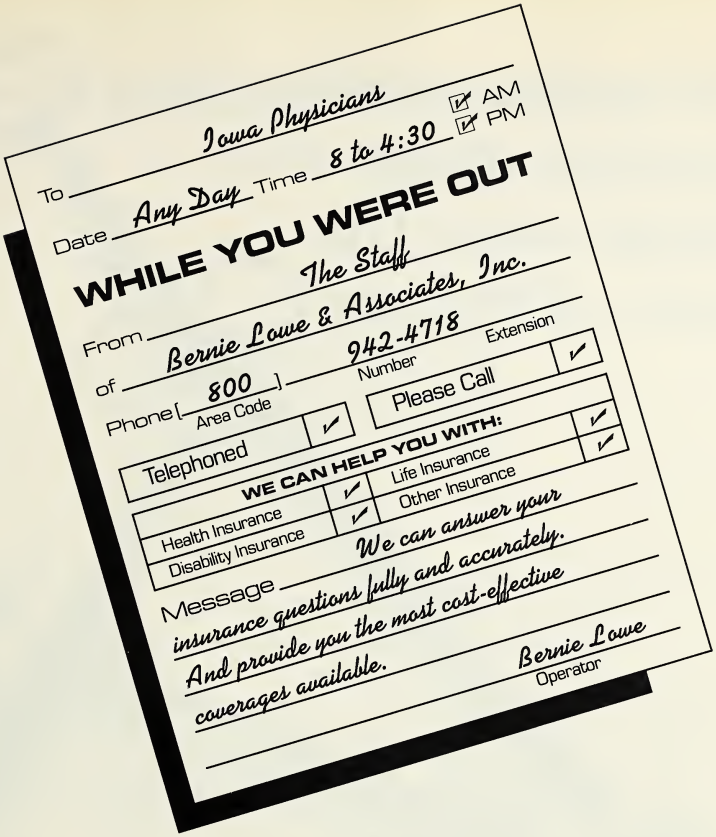
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Iowans with intestinal bypass—a status report

Are you following up on patients who underwent intestinal bypass for morbid obesity? Have you ruled out progressive damage to kidneys, liver or bones? These authors believe conversion to vertical banded gastroplasty should be considered.

Joseph Cullen, M.D.; Edward Mason, M.D., Ph.D.; Themis Economou, M.D.; David Scott; Cornelius Doherty, M.D.; and James Maher, M.D.
Iowa City, Iowa

OVER 1,000 JEJUNOILEAL BYPASS operations were performed in Iowa in the last 30 years.[1] Although the exact number of intestinal bypasses performed is unknown, it is estimated that approximately 25,000 Americans underwent this procedure.[2] The post-operative fate of many of these patients is unknown.

The first intestinal bypass procedures were performed in 1954 and modified in the early 1960s.[3] Because of its technical simplicity and initial success in the areas of weight loss, glucose tolerance, hypertension, cardiac disease, pulmonary function and hyperlipidemia, jejunoileal bypass became the operation of choice for morbid obesity.[4] However, with time, surgeons all but abandoned the operation due to late complications including renal disease, diarrhea, malnutrition, electrolyte abnormalities, bone disease and liver disease.[5]

The authors are affiliated with the University of Iowa Hospitals and Clinics Department of Surgery.

Materials and methods

This is a retrospective review of 82 patients with intestinal bypass seen at the University of Iowa Hospitals and Clinics between 1977 and 1991. Twenty-five patients had a gastric restrictive operation (either gastric bypass or vertical banded gastroplasty—VBG) following an intestinal bypass takedown; 57 patients had intestinal bypass takedown with a concomitant gastric restrictive operation. Thirty-six patients had a VBG and the other patients have had some form of gastric bypass including loop gastric bypass and Roux-en-Y gastric bypass. The mean age of the 82 patients was 40 (+10) at the time of their UIHC admission, ranging from 22 to 61 years of age.

Results

One patient died of a pulmonary embolism two weeks postoperatively while at home. Since 1980 when vertical banded gastroplasty became the operation of choice for morbid obesity, this was the only death in the 36 patients who had intestinal bypass takedown and concomitant VBG.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR NOVEMBER 1993

Operative time increased 30 minutes in patients who had combined intestinal bypass takedown and gastric restrictive operation (203 minutes) versus those who had prior intestinal bypass takedown (173 minutes).

Almost all patients who have restoration of their intestinal continuity as the only procedure return to their pre-intestinal bypass weight, usually within a year. Figure 1 shows the weight of those patients for five years after sequential and combined procedures. Patients with a prior takedown had a significant initial weight loss that remained stable five years afterwards. Likewise, patients who had the combined procedure had a steady baseline weight. Understandably, patients with a previous takedown will begin at a more obese level because of the weight gain after restoring intestinal continuity.

A number of patients arrive in a severe state of protein depletion and require a long course of parenteral nutrition to prepare for operation. Twelve of the 58 patients who had reversal of intestinal bypass and a concomitant gastric restrictive operation spent 10 days or more in the hospital, while only one of the 25 patients who had a previous intestinal bypass takedown and later gastric restrictive operation spent 10 days or more in the hospital prior to the gastric restrictive surgery.

Discussion

A number of points should be made regarding patients with jejunoileal bypass. First, they need to be followed periodically for life. Assessment of nutritional status is extremely important. Prior to takedown and gastroplasty, depleted nutritional stores should be replenished. Malnourished patients with low serum proteins and electrolyte disturbances require a prolonged and progressively intense course of hyperalimentation in the hospital. Oral feedings fail to restore body protein. Bringing the nutritional state to a satisfactory level decreases postoperative morbidity and mortality.

Body weight and initial serum protein levels may be unreliable indices of the severity of malnutrition. While nutritionally resuscitating a patient, total body weight loss can be an early index of improved colloid osmotic pressure

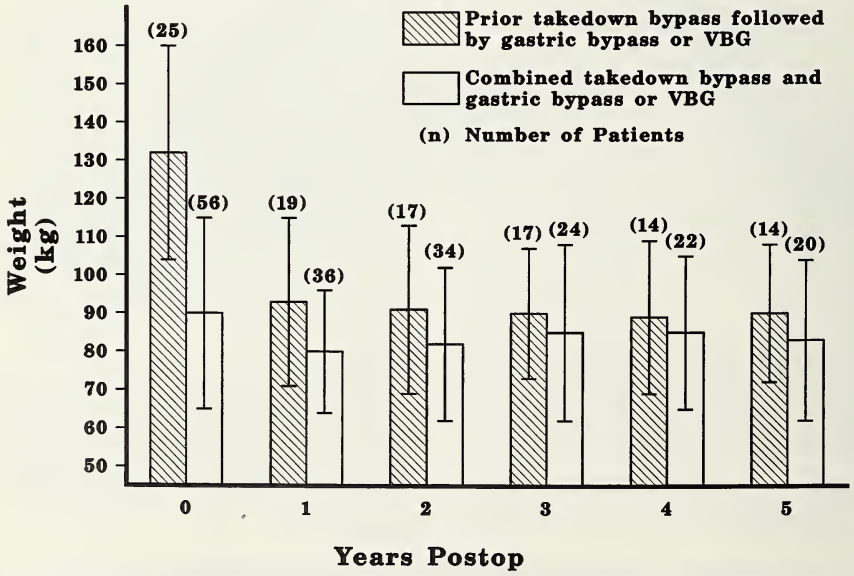


Figure 1. Weight patterns for five years following a gastric reduction operation comparing prior and concomitant restoration of intestinal continuity.

due to improvement of body protein stores.[6] A sustained albumin level without exogenous albumin administration and increasing body weight without evidence of fluid retention are late indices of replenished body protein.

Secondly, patients with jejunoileal bypass should be referred for restoration of intestinal continuity because of the severe and life-threatening long-term complications including renal disease, diarrhea, electrolyte abnormalities and cirrhosis. Many of these patients will have symptoms attributable to the intestinal bypass but a number will go unnoticed until liver dysfunction, including cirrhosis and ascites, become apparent. After years of well-being with jejunoileal bypass, patients can develop sudden and severe metabolic consequences.[7]

'Almost all patients who have restoration of their intestinal continuity as the only procedure return to their pre-intestinal by-pass weight, usually within a year.'

Some authors feel that asymptomatic, reliable patients with jejunoileal bypass who require no medications to treat the complications of the intestinal bypass (including antidiarrheal medication), no histological evidence of hepatic fibrosis, a normal creatinine clearance, no nephrolithiasis and normal bone density radiographically, can be followed.[7] Therefore these asymptomatic patients should have periodic liver biopsies, determinations of creatinine clearance and evaluations of bone density as part of their routine long-term follow-up. If these tests show liver fibrosis, declining renal function or bones are becoming less dense, serious consideration should be given to restoration of intestinal continuity.

Finally, vertical banded gastroplasty should be added to the takedown procedure. Although some authors feel gastroplasty at the time of reversal of the jejunoileal bypass will increase morbidity and mortality, our experience and that of others suggests a concomitant gastric restrictive procedure is safe, provided abnormalities in total body protein have been corrected.[8,9] Weight control is usually maintained when the two procedures are performed concomitantly and the complications of obesity can be avoided.

Many patients are reluctant to undergo takedown of the jejunoileal bypass due to fear of weight gain. If patients are educated regarding alternative and safer operations for continued weight maintenance, they may be more willing to have reversal of their intestinal bypass before complications develop. Patients who insist upon keeping their intestinal bypass should be advised to undergo periodic evaluations of their liver, kidneys and bones.

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Osler and Iowa

Richard M. Caplan, M.D.

A FRIEND WHO LIKES TO chide me—in part by holding me responsible for weaknesses he discovers in persons whom I admire—recently did so by drawing attention to a remark of Sir William Osler quoted in Cushing's massive 1925 biography of that revered physician. My friend found Osler saying "I am lowering my record at golf which is the only matter of interest to me just now."

Since the comment was recorded for August, 1898, when Osler was healthy and vigorous, my friend challenged me to summon a defense of Osler, who must have always been truthful, but surely couldn't have been speaking literal truth on that occasion. For one thing, Osler was well known as a practical joker, which by definition implies at least some shading of the truth. For another thing, can an idol be a true idol without a little clay on the feet? In this case the response is simpler: it's a matter of understanding the context and meaning of Osler's phrase "just now."

My friend's reading was ahead of me, because at the time of that discussion I'd not begun reading the huge biography which won Dr. Harvey Cushing a Pulitzer Prize. Now that I've set myself to the pleasant chore of reading, I find two other tidbits of interest on that same page. The first appears in the following sentences where Cushing says, "But the remainder of his summer was to be badly broken up and spent for the most part in trains. He had been summoned to Buffalo [N.Y.], and from there had gone on to see a patient somewhere in Iowa." Think about that for a house-call(!) and by one of the nation's most prestigious consulting physicians.

At the top of that page 478, in a letter from Bar Harbour to his assistant in Baltimore, Osler writes, "Campbell and Muriel Howard are here. Mrs. Osler asked them as a surprise to me." Few Iowans might recognize now that Campbell Howard was a son of Osler's Dean and mentor at McGill, a godson of Osler himself, and in 1910 was Osler's suggestion to U of Iowa President McLean, who was seeking a new chief of medicine in response to some stinging assessment in the famed Flexner report of that year. McLean successfully completed the negotiations with Campbell Howard, who served as Iowa's head of Internal Medicine from 1912 to 1924.

Another Iowa connection appears on page 509 where Osler is quoted in a brief note to a former McGill student, Dr. J.H. Darey, whom in 1886 Osler "had sent out to Iowa for his health." Osler's note of Nov. 17, 1899 said in part:

> I was very glad to hear from you. My address [speech] has called out letters from several of my old Montreal boys. What a hard road you have had to travel! I feel sure you will settle down to peace and mental quiet as the years pass. A steady uniform life, ½ speed, as little stress and strain as possible should obviate the tendency to these recurrent attacks.

The medical student curriculum at the U of Iowa is presently being reviewed, just as is happening at most U.S. medical schools, and will no doubt experience some changes. One of Osler's observations, made during an 1899 talk to McGill faculty and students, was really an old one, often repeated but seldom if ever tested:

> Undoubtedly the student tries to learn too much, and we teachers try to teach him too much—neither, perhaps, with great success. The existing evils result from neglect on the part of the teacher, student and examiner of the great fundamental principle laid down by Plato—that education is a life-long process, in which the student can only make a beginning during his college courses. . . . We can only instill principles, put the student in the right path, give him methods, teach him how to study, and early how to discern between essentials and nonessentials.

It's because of such breadth of learning and experience that Osler is counted as a great medical humanist. I wonder how close we'll come to his goal on this round of curriculum revision. The ancient Greeks understood the myth of Sisyphus. So should we.

Dr. Caplan is Coordinator, Program in Medical Humanities at the University of Iowa College of Medicine.

Eight ways to improve time management

HOW MUCH IMPORTANCE do you place on your time? Does your time control you, or do you control it? If you are like most practitioners, time management is the most critical part of your practice success. Following are some ideas to help you improve your ability to control your time.

1. ***Analyze and set your time priorities.*** Clarify your goals. This forces you to examine the importance of issues in your professional and personal life. Setting time management goals forces you to focus on the results you want.

2. ***Schedule regular physician/office staff meetings.*** Setting up regular meetings promotes communication. Good communication, in turn, will help the efficiency of the office. There are many times when office meetings would improve your satisfaction with the way the office operates.

3. ***Ask for employee involvement.*** Your office staff should function as a team. This team has many players and each player needs instructions to help them manage their time. Many times, employees can come up with solutions to problems, but they might not come forward with their suggestions for improvement. Getting the employees involved also produces commitment to be part of the solution.

4. ***Learn to delegate.*** Let's face it, if you tried to do everything that needed to be done in your office, you could work 24 hours a day, seven days a week, 365 days a year. To solve this problem, you need to make certain the right people are doing the right jobs. Are there things your staff could do for you? Learn to let go of those things that can and should be handled by someone else.

5. ***Keep a visible schedule.*** Always be aware of your time. Keep a list handy of those things you have to do. Checking the list regularly will remind you of your priorities. It will reinforce the need to get things done.

6. ***Manage telephone interruptions.*** How many calls do you receive that are put directly through to you? This causes an interruption in your schedule. Are calls from your accountant or broker that critical, or could you have a message taken and return the call during a scheduled time? If you are receiving a high number of interruptions from non-urgent phone calls, you may want to instruct your staff to take detailed messages.

'Good communication will help the efficiency of the office. There are many times when office meetings would improve your satisfaction with the way the office operates.'

7. ***Dictate as much as possible.*** You can dictate records, letters and notes at least twice as fast as you can write them. In addition to saving time, typewritten documents present a much more professional appearance than hand scribbled notes.

8. ***Keep your records organized.*** Offices that look like a disaster area, in fact, create disaster. Too much time is wasted looking for documents in unorganized offices. If it takes you 10 minutes every day to find documents, you are throwing away five nine-hour days out of the year.

If you want to improve your time management, following the above suggestions is a good start. By making a commitment to improve your time management, you have already accomplished part of step number one.

This article was written by Steve Irwin, a certified professional business consultant with Professional Management Midwest, Inc.

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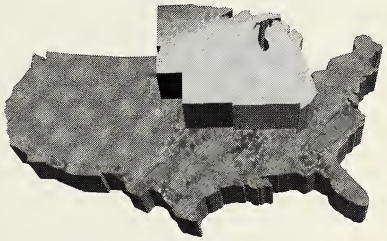
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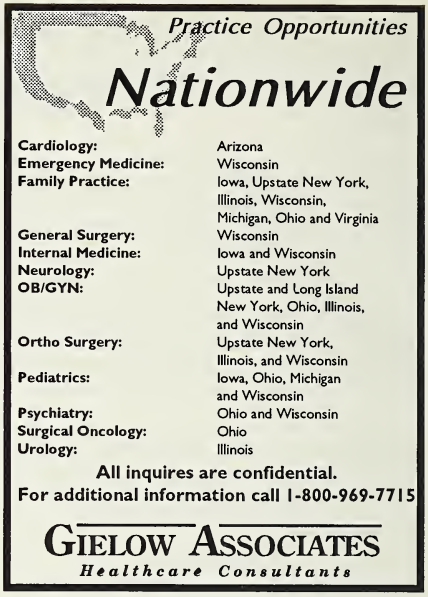
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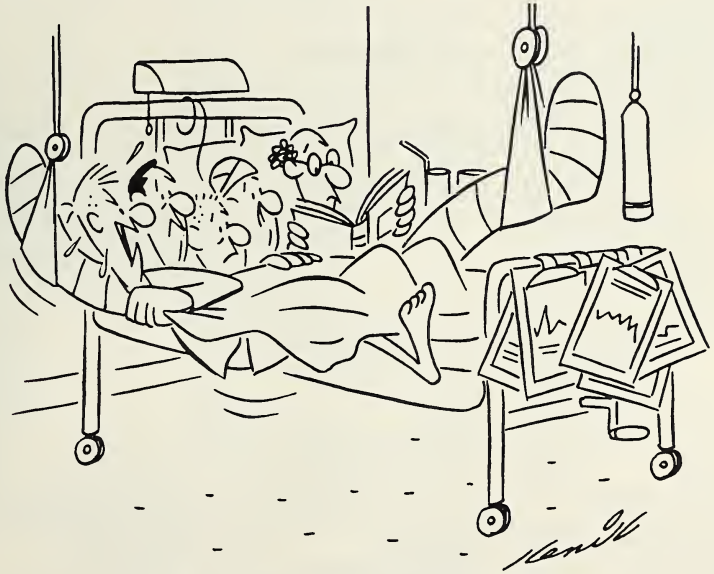
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John Anderson, M.D.

Let's hang in there

IN LATE OCTOBER, THE CLINTONS submitted their 1300-plus-page health system reform plan to Congress. The actual plan had some changes but was about what everyone anticipated. The president and first lady are to be congratulated for bringing health system reform to the forefront for public debate. Nobody can dispute the six principles outlined in the plan unless you are against motherhood and apple pie.

The plan does outline many of the goals physicians have been striving for and that are contained in the AMA's Health Access America. The plan includes universal access, health insurance reform, a benefit package similar to the AMA's and an employer's mandate to provide health insurance to employees. I understand this topic is to be revisited this month at the interim AMA meeting in New Orleans.

In essence, the intentions in the Clinton plan are good. However, under close examination the plan has some serious flaws and defects. Heading the list is the tremendous layer of bureaucracy that would be established with state alliances and a national board. Yet another national board would be set up to regulate the number and kind of residencies we have across the land. A global budget and price controls on insurance premiums most certainly would lead to rationing. Only token malpractice and antitrust reform are included. The one item that would affect Iowans most is a proposal to partially fund the plan through a $124 billion cut in Medicare. This would be devastating to rural Iowa.

In early October, Congressmen Grandy and Cooper introduced a bipartisan plan that bears watching. The bill presently has 50 cosponsors from both sides of the aisle. It has no employer mandate but requires employers to form a conduit through which employees can purchase health insurance. It has much less bureaucracy and regulation, less severe Medicare cuts and much better tort reform.

The Governor's Health Reform Council is also working hard to have a proposal ready next month. The Council has heard reports from all of its 16 subcommittees. They are planning a statewide teleconference on January 5th to obtain public reaction to their proposal.

My point is to stay informed, stay involved and, above all, stay united. Talk to your patients. Talk or write to your federal and state legislators. Let the IMS know your feelings, too. This is going to be a long difficult fight. Hang in there . . . but let's hang in there together.

I wish everyone a very safe and healthy holiday season.

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Marion E. Alberts, M.D.

Are you truly educated?

MOST PHYSICIANS HAVE followed this educational course . . . four years of undergraduate pre-medical classes in college. Four years of medical school. Three to six years of post-doctoral training. Then, after entering practice there are continuing medical education requirements. Yet after all this education, are you truly educated or are you trained in medicine?

Many graduates of colleges and universities in recent years are not truly educated. After four to six years of exposure to crowded lecture halls and graduate assistants rather than professors of tenure and esteem, the graduate thinks a full education has been attained. Many, perhaps, are trained in a narrow field: business administration, medicine or the engineer trapped in a science by which the properties of matter and the sources of energy in nature are made useful to man.

What of the fullness of life? The truly educated person has a knowledge of many interests outside the training received for a life's vocation. There are many modalities of life experiences that are foreign to many so-called educated persons. Life is more than cloistering oneself in a specialized endeavor without exposure to and appreciation for many other experiences.

What kind of outside activities do you enjoy? Just golf? Just gardening? Reading only medical literature? Going to an expensive resort to eat, drink, be merry and play golf? What subjects did you take in undergraduate school other than biological sciences and the required English, history and mathematics?

My point is that most physicians are not educated in the broadest sense of the meaning of education. Abraham Flexner, American educator, once said that "without ideals, without effort, without scholarship, without philosophic continuity there is no such thing as education." He noted that nations borrow billions for war, but no nation has borrowed largely for education. Horace Mann, another noted American educator, observed that "education alone can conduct us to that enjoyment which is, at once, best in quality and infinite in quantity."

Quantity is the keyword in Mann's statement. A true education provides knowledge in the arts, history, philosophy, logic, literature, theology as well as one's chosen field of training. One must have a full life, snatching every facet of knowledge available. Read something other than medical literature. Develop an interest in music (other than possessing the best stereo equipment available). Be alert to all of life around you and let (no, *make*) yourself be involved in something other than medicine. You will be happier for it and surely your family will reap benefits as well. Seek further visions of the world around you. Ignite in your inner self new vistas of knowledge. Then surely you can consider yourself truly educated.

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Legislature will address health system reform in 1994

What will be the IMS priorities in the 1994 Iowa Legislature? This year, there is no shortage of key issues.

Kevin Cunningham, M.D.
Des Moines, Iowa

THOUGH NO ONE CAN PREDICT exactly what form it will take, the Iowa Legislature is sure to seriously consider some type of health system reform when it convenes in mid-January.

Health system reform was certainly high on the agenda for the Iowa Medical Society's Committee on Legislation when it met this fall to formulate priorities for the 1994 legislative session. These priorities—which deal with health system reform and other important issues—have received final approval from the IMS Board of Trustees. Because many critical issues evolve throughout the fall, other issues could arise which are not included in this article.

Fast start predicted

The 1994 state legislative session will begin on Monday, January 10. This will be the second session of the two-year legislative cycle, which means it is likely to get off to a faster start than in 1993. Legislators are particularly concerned again this year about the state budget. The effects of the 1993 floods on the economy and state revenues are being monitored closely. The revenue situation will govern the legislature's ability to address other issues.

The Iowa Health Reform Council is scheduled to submit recommendations to Governor Branstad on December 15. As of this writing, the 58-member council and its 16 subcommittees are working on various aspects of the reform effort, but recommendations have not yet been formulated. Governor Branstad will review the Council's report in developing his recommendations to the legislature. By the time you read this, those recommendations should be available.

The IMS has been involved with the Council through the participation of physicians on the Council and its subcommittees. Tim Gibson of the IMS staff has also played a significant role in providing staff support to the Council. These individuals have been strong advocates for patients and have done a good job of representing the concerns of the medical community.

Liability reform must be part of health system reform

Among IMS priorities for the 1994 legislative session are several other issues which are related to health system reform.

The IMS strongly believes, as does the AMA, that health system reform will not work without significant reforms in the tort liability system. The IMS continues to advocate meaningful reforms such as a cap on noneconomic damages and a reduction in the statute of limitation for minors.

These proposals will go a long way toward reducing the need for defensive medical practices which have contributed to increases in the cost of medical care over the

(Continued next page)

Dr. Cunningham, a Des Moines internist, is chairman of the IMS Committee on Legislation.

last few decades. In addition, liability concerns have been a key factor in the decision of many of our colleagues to discontinue obstetrical services and a disincentive to others who provide care considered high risk. Meaningful liability reforms under any system will help maintain access to care for Iowans.

The use of practice parameters or guidelines has been discussed extensively in the context of health system reform. Legislators and other public policymakers have been interested in practice parameters as a possible method to ensure quality medical care, provide some liability protection to physicians and to reduce health care costs by reducing the need for defensive medicine.

The IMS is initiating a pilot project to assess the feasibility of developing a state process of review of practice parameters developed by national specialty societies. The objectives of our study are to test a physician-directed process of dealing with practice parameters and to provide the IMS with direct experience with practice parameters to use during public policy discussions of health system and liability reform.

The IMS believes that any system of review or approval of practice parameters should be directed and accomplished by physicians. A few other states have passed legislation relating to practice parameters. Some of those, such as Maine, provide that adherence to approved practice parameters, is an affirmative defense for the physician defendant in an action for medical malpractice. We are watching these and other states' projects with a great deal of interest.

CHMIS: electronic billing or something more elaborate?

Some of you may have heard about a proposed Community Health Management Information System, known as "CHMIS."

A CHMIS would provide for greater use of electronic media within the health care system. Proposals range from simply encouraging electronic billing and claims payment to much more elaborate and expensive proposals to create a large central repository of electronic data, including patient medical records. The IMS supports electronic billing and claims payment and mandatory use of standard claims forms but opposes development of a central repository for patient records.

The Iowa Legislature mandated a study of a CHMIS system in 1993 with a report due in November 1993. The IMS has been represented on both the steering committee and subcommittees. The steering committee has discussed various plans and has formulated preliminary recommendations.

Due in large part to physician concerns about patient confidentiality, as well as the high cost, a central repository for medical records is not part of the steering committee's preliminary recommendations. Recommendations provide that information will be collected from claim forms, similar to current collections of hospital and surgical data and similar in content to the proprietary databases maintained by third party payers. Strict confidentiality protections are necessary, even for this more limited system.

Another legislative issue relating to communications technology will be of interest to physicians. Access to the state's fiber optic communications network by the medical community is expected to be considered. Currently the state network may only be used by educational institutions, but there is considerable interest in making it available to the health care community. The IMS has not had a position on this issue in the past, but you may be hearing more about it in the future.

IMS has extensive public health agenda

The IMS has been active in recent years on a variety of public health issues. Most of us consider ourselves to be advocates for our patients. It is in our role as patient advocates that the IMS has developed a public health agenda.

It is our responsibility as physicians to provide legislative and community assistance on health issues such as promoting a tobacco-free environment and use of safety devices like child restraint seats in motor vehicles and helmets by motorcyclists. Over the years we have had a significant impact in the Iowa legislature on public health issues. And our involvement reminds legislators that our primary concern is for the health of Iowans.

Our 1994 public health agenda includes continuing to work with the Tobacco Free Coalition on legislation to provide a tobacco free environment for Iowans. Key coalition members in addition to the IMS are the American

Lung Association, the American Heart Association, the American Cancer Society and the Iowa Department of Public Health.

Likely components of the Coalition's 1994 legislation include improving enforcement of the existing Clean Indoor Air Act by designating the Iowa Department of Public Health as the lead enforcement agency. It makes sense to designate the state's main health agency to have responsibility for this area. Current responsibilities are shared by a variety of state and local entities with no one in charge. In addition, the coalition also seeks to prohibit smoking in hallways in office buildings, all worksites and licensed day care centers, and to require greater separation of smoking areas from nonsmoking areas in restaurants.

Helmet law is a health and safety issue

The IMS will also continue to work with the Helmet Law Coalition in support of legislation which would require all motorcyclists, including passengers, to wear federally approved headgear. The federal government requires states to enact comprehensive helmet use legislation for motorcyclists or face diversion of a portion of federal highway construction funds. An attempt made in 1993 to replace the diverted funds with a higher fee for nonhelmeted motorcyclists was passed by the legislature in 1993 and was vetoed by Governor Branstad. We sincerely hope that the 1994 legislature will pass a "real" helmet law.

While opponents of helmet laws have tried to portray this issue as one of individual choice and individual rights we believe it is a health and safety issue. Motorcycles are one of the few modes of transportation where taking routine safety precautions is not required. Lives are saved—and equally important, quality of life is maintained—by the proper use of helmets.

At the direction of the 1993 IMS House of Delegates we are beginning a process of review of Iowa's laws relating to AIDS. Because it has been several years since the first laws were put on the books, the House decided a review was needed. This review is only beginning and committee work will be needed before specific changes are recommended. Iowa physicians can be proud of the fact that while Iowa's laws may not be perfect and cause us occasional frustration, Iowa legislators look to the IMS for leadership on the issue. As a result, Iowa has avoided laws that are punitive for either physicians or patients.

'The IMS strongly believes, as does the AMA, that health system reform will not work without significant reforms in the tort liability system.'

The IMS also monitors the appropriations process. Items of particular interest include Medicaid reimbursement and cost saving measures, funding for the Board of Medical Examiners, the Statewide Family Practice Residency Program and the state medical examiner's office under the Department of Public Safety.

The Department of Human Services has recommended increasing Medicaid reimbursement for EPSDT screening for children and obstetrical care. The department has requested these increases to comply with federal requirements to maintain access to these services.

Medicaid costs a major issue

Medicaid cost containment has been a major legislative issue for the last few years as legislators have struggled to balance the budget. Past cost saving proposals have resulted in increased use of managed care for Medicaid patients and requiring prior authorization for certain prescription drugs. Because of possible budget shortfalls it is likely that legislators will again look for ways to restrain the rate of increase in the Medicaid budget. Physician services accounted for approximately $77 million, or 8.4% of the $913 million Medicaid budget in the fiscal year which ended June 30. Prescription drugs account for slightly more than physician services.

The Department of Public Safety has requested additional funding for the state medical examiner's office, which would provide additional support for county medical examiners. Many IMS members perform this important public service at the local level. Sup-

(Continued next page)

port and assistance for these individual physicians will help ensure that the public safety system functions as well as possible.

The Statewide Family Practice Residency Program is essential to ensure availability of family physicians to practice in both rural and urban areas of Iowa. The IMS supports adequate funding for this program and additionally provided support for the University of Iowa College of Medicine's Primary Care Initiative in 1993.

The IMS believes that the Board of Medical Examiners should be fully funded through the appropriations process. Iowa law requires that physician license fees be set at a level to fund the operations of the Board. The IMS believes that revenue collected through this mechanism should be appropriated to the Board to allow it to perform its duties.

Budget issues will be important again this year. While the IMS as an organization usually does not involve itself in debates over taxes, it is a different story when tax proposals affect our patients and our ability to provide care.

The IMS will continue to oppose a health care tax or increase in fees to balance the state budget. As many of you recall because you played a key role, the IMS led a coalition in 1992 which was successful in defeating a proposal to impose a tax on health services. While Governor Branstad has stated he will not propose such a tax again, the issue could surface in budget discussions.

This issue is one of the best examples in recent years of how physician involvement in the legislative process can turn an issue around. Iowa physicians contacted legislators in record numbers to help them understand the effects a health care tax would have on patients and the health care delivery system.

Keep the spirit of unity alive

We need to keep this spirit of unity alive as we deal with other issues, particularly health system reform. While working together and participating in the process are not a guarantee of success in the legislative arena, choosing not to stand together and participate in the process will almost certainly guarantee failure. And most important, we need to let our elected officials know the effects of proposals on our patients. We are patient advocates. Our collective voice should be heard the loudest defending our patients.

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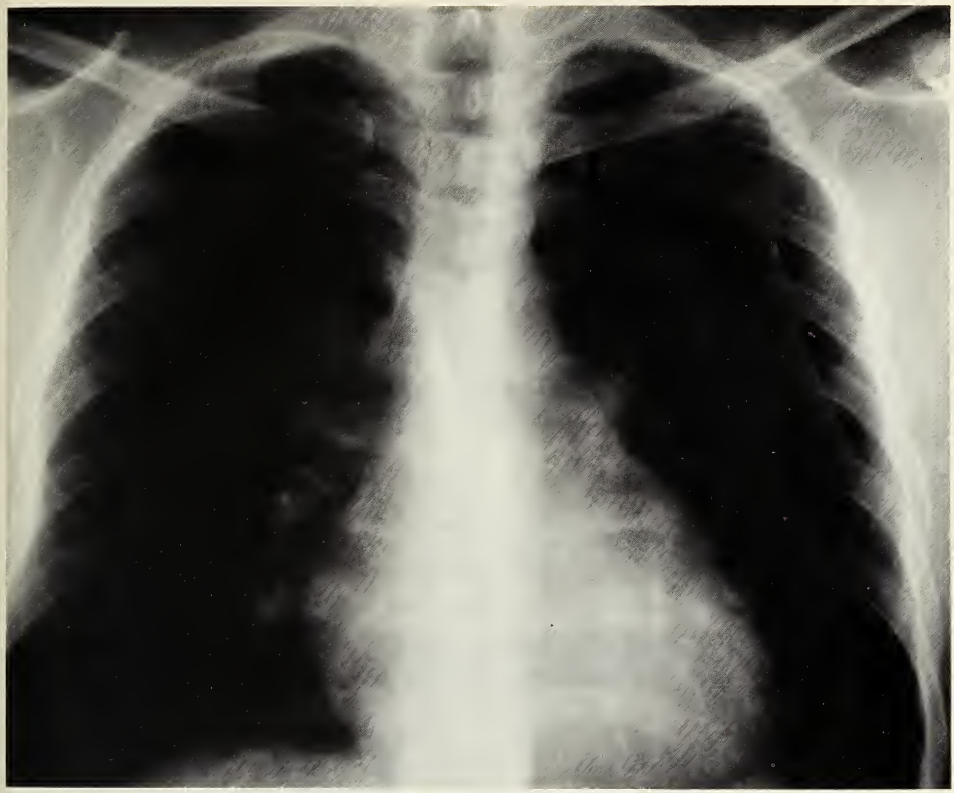
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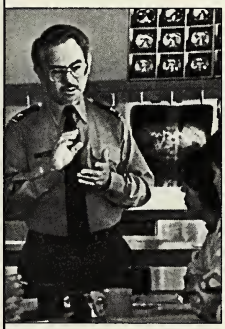
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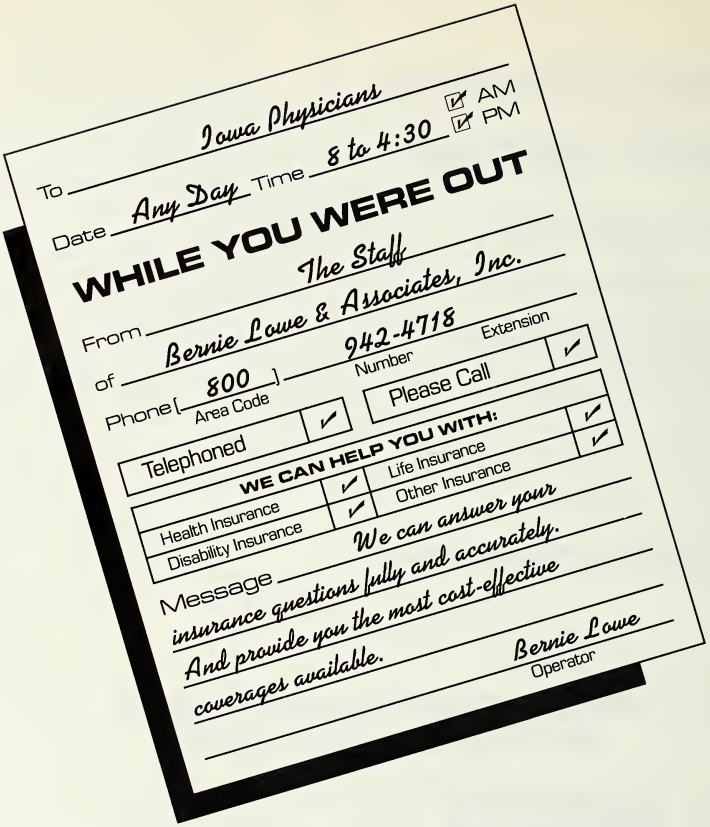
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Food allergies: how common are they?

Food allergies are probably not as common as many people believe, but they definitely exist, says this expert.

James Wille, M.D.
Des Moines, Iowa

IT SEEMS ALMOST EVERYONE you know has had or believes they have had an adverse reaction to a food, food additive, coloring or preservative at some time in their life. Although the true prevalence of allergic reaction to foods is unknown, the *Federal Register,* quoting the U.S. Department of Agriculture in 1983, estimated that 15% of the population is sensitive to a specific ingredient in food.

However, 480 children were prospectively studied from birth to three years of age and 28% were suspected of having a food induced symptom by history. Confirmed reactions were found in 8% and much fewer were found to have an immunologic basis.

History of awareness

We developed a collective concern about food reactions through a variety of pathways. Hippocrates (460-370 B.C.) recognized that cow's milk could cause gastric upset and hives. The Roman poet Lucretius said, "One man's meat is another man's poison." Food allergy is popular in the lay press and has been blamed for many types of physical or psychological symptoms, from bedwetting to hyperactivity to behavior disorders and even blatant schizophrenia. Physicians and patients accept anecdotal association as fact, generally without objective confirmation.

A discussion of terminology is important. An **adverse reaction** to a food is a general term used to describe any clinically observed response attributed to a food or additive. A **food allergy/hypersensitivity** is an adverse reaction to a food for which an IgE mechanism can be identified.

The diagnosis of food allergy may be simple or quite exasperating. It begins with a detailed history of symptoms, their relationship to meals or snacks (timing, amount, specific foods), how long they last, any prior treatment and if emergency care was sought. It is necessary to find out what other medications the patient might be using (including OTC variety), other medical conditions and other exposures around the house or work (pets, feathers or down, smoking, woodburning, chemicals). Is there a seasonal component or does it only happen at work or at home? What is the family history of food allergies, nasal allergies, asthma, atopic dermatitis and urticaria?

After a complete history and physical exam is accomplished, tests to determine the presence of IgE senstitivity to foods are usually undertaken. These tests include skin testing, radio allergo-sorbent tests (RAST), the enzyme linked immunosorbent assay (ELISA) and leukocyte histamine release. These tests cannot predict which sensitized patient will react clinically to food challenge, but can only indicate

Dr. Wille is a pediatric allergist practicing in Des Moines.

THE IMS EDUCATION FUND HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION AWARD FOR DECEMBER 1993

the presence of IgE antibody to food. They have a good negative predictive value, but poor positive predictions. That is, a negative test says the food is not involved through an allergic mechanism, but a positive test does not automatically mean that food is causing the patient's symptoms.

Skin testing (prick or puncture) produces immediate results, is less expensive and is considered to be more sensitive than *in vitro* methods. Intradermal testing is less predictive than prick tests and is not recommended. RAST and ELISA testing should be reserved for patients who have severe dermatitis or dermographism or those in whom there is a significant risk of adverse reaction during skin testing (such as those with a history of anaphylaxis). These tests are more expensive, somewhat less sensitive and require a good reference laboratory.

The leukocyte histamine release test is without advantage over the preceding tests and currently its use is limited to research. At the present time, there is no evidence of any diagnostic value for food specific IgG or IgG4 antibody levels, food antigen-antibody complexes, evidence of lymphocyte activation (e.g., interleuken-2 production) or sublingual or intracutaneous provocation.

Bacteria can mimic food allergy

At the present time, there is no reproducible evidence that type II (cytotoxic antibodies), type III (immune complex) or type IV (cell mediated, delayed hypersensitivity) reactions cause food allergy. A **food idiosyncrasy** is an intolerance resembling an allergy that may occur in genetically predisposed persons, such as those lacking certain digestive enzymes (e.g., lactose intolerance). A **food toxicity** is an intolerance caused by toxins contained in foods or released by microorganisms or parasites contaminating food (e.g., tunafish releases histamine produced by bacteria). **Natural pharmacologic agents** in foods can also mimic food allergy (e.g., tyramine found in cheeses and red wine and phenyl ethylamine found in chocolate).

Although allergic reactions can occur to any food, most reactions are triggered by relatively few foods: milk, egg, peanut, soy, tree nuts (walnuts), fish, shellfish, wheat, corn and citrus. Most allergic reactions begin within a few minutes to a few hours after ingestion. A few very sensitive patients may develop symptoms simply by smelling or touching the food. These reactions result from the interaction of food antigens (to which the patient has been previously sensitized) with IgE antibodies fixed on mast cells in the intestinal tract, skin, lungs and circulating basophils. The mast cell then releases chemical mediators which include histamine, proteases, eosinophilic chemotactic factor and neutrophil chemotactic factor.

In the gut, mediator release can result in nausea, cramping, abdominal pain, distention, vomiting and diarrhea. As food antigen gains access to the circulation and affects other target organs, nongastrointestinal symptoms such as urticaria, angioedema, rhinitis, wheezing and asthma, laryngeal edema, hypotension, shock, and anaphylaxis can develop.

Solving a mystery

An exclusive diet eliminating all foods suspected by history and/or skin testing can be conducted for one to two weeks in suspected IgE mediated disorders. However, this should never be attempted with foods thought to cause anaphylactic reactions. If no improvement is noted, it is unlikely food allergy is involved. If there appears to be some correlation with symptoms and ingestion of a particular food, another elimination with subsequent challenge of the food needs to be repeated two more times.

Another alternative is the double blind, placebo-controlled food challenge (DBPCFC) which is the gold standard of food allergy testing. In this method, a third party such as a pharmacist can "mask" the suspected food in opaque, dye-free capsules to "blind" both the physician and the patient (and parents) for bias, psychologic factors and other external matters (e.g., texture) that could affect the objectivity of the results. However, the DBPCFC is difficult and time consuming and may need to be performed in a hospital or clinical research setting.

Once the diagnosis of food allergy is confirmed, the only proven therapy is to avoid the food. Patients and their parents must learn to read labels and "ask before eating." In some cases, strict adherence to the elimination diet appears to promote the process of outgrowing a food allergy. Certain food allergies such as peanut, fish and shellfish may last a lifetime. Patients with a history of severe, life threaten-

ing or anaphylactic reactions need to have self-administered epinephrine available (EpiPen or Anakit) and a plan of action in the event the food is eaten accidentally.

Oral antihistamines can be helpful if the reaction is mild. A Medic Alert bracelet would be appropriate to identify a patient with a severe food allergy. Currently, there are no medications, including H_1 or H_2 antihistamines, cromalyn sodium, or steroids that can be used prophylactically to alter a food allergic reaction. These meds also do not alter the long-term course of the problem. Allergy shots and sublingual drops for foods may be dangerous and are not recommended.

Reactions to additives

What about reactions to food additives, preservatives and dyes? Yellow No. 5 (tartrazine) is used to color foods, beverages and candies. There is no convincing evidence that asthma can be provoked or that ASA sensitive patients tend to cross react with tartrazine containing foods. Fewer than one out of 10,000 persons will develop hives after eating tartrazine. MSG

'In prospective studies of adverse food reactions in infants, 80% to 87% of confirmed symptoms were no longer observable by three years of age.'

(monosodium glutamate) is used as a flavor enhancer. A small number of persons may experience flushing of the face, chest discomfort and nervousness known as "Chinese Restaurant Syndrome," but this is not mediated through an immunologic mechanism.

Sulfiting agents are antioxidants used as preservatives for foods. They are capable of causing severe asthma in sensitive patients; their use on fresh fruits and vegetables was banned in 1986. Sulfites are still used in some packaged foods and wines and do not cause a problem in most patients.

Again, it is not thought that IgE or other immunologic mechanisms are involved in these adverse reactions. Aspartame (Nutrasweet®) has been implicated as a trigger mechanism for a variety of disorders including asthma, gastroenteritis, eczema and urticaria. After 10 years of monitoring complaints and reviewing a number of controlled clinical studies, the FDA has concluded there is no convincing evidence of cause and effect relationship.

Clearly, food allergy exists. Is it common or uncommon? It is certainly less common than generally thought, but any problem that may affect up to 15% of the population deserves our attention. Food allergy is typically limited to a very small number of foods, or more likely, one food. Avoidance remains the mainstay of therapy. Education about the natural history of food allergy is important. In prospective studies of adverse food reactions in infants, 80% to 87% of confirmed symptoms were no longer observable by three years of age.

Exclusive breast-feeding for the first six months of life with careful attention to the maternal diet may ultimately prove to be most beneficial. It is important to understand the limits of skin testing and other laboratory tests. Physicians should also remember that good health and growth can suffer if patients are placed on strict avoidance diets which may not allow for sufficient calories and protein.



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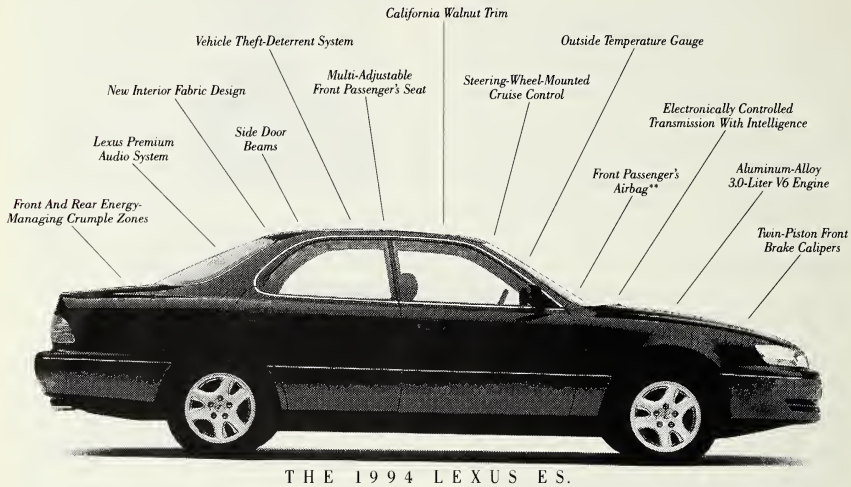
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Brave new world and CME

Richard Nelson, M.D.

THE CLINTON ADMINISTRATION'S health care reform proposal has been delivered to the Congress. Its 1300 pages spell out changes designed to increase access to medical care for millions of Americans and contain the inflationary growth of health care costs in the country.

Overlooked in much of the debate about health care reform is the impact of these changes on continuing medical education. What are we to expect?

There is little controvery regarding the need to increase primary medical care resources in the United States. The current undersupply of primary care physicians in many regions will likely intensify if more citizens have access to preventive and acute illness care. Inevitably, the providers of CME will be called on to assist practicing physicians to hone their primary care skills. While the notion of an ophthalmologist retraining to be a primary care physician seems somewhat extreme to most physicians, the desirability of a cardiologist in a managed care plan providing some degree of primary care is much more feasible. The majority of practicing cardiologists in today's system may have had little recent experience in the provision of primary care. They (and their practice groups) may soon be looking for courses and educational materials to improve their primary care capacities.

An even more profound change in the delivery of CME may result in the intense interest of physician practice groups and managed care plans that their physician constituents provide care that meets or exceeds practice guidelines or parameters. Such high-quality care will be necessary if the groups and plans are to competitively obtain contracts to care for populations of patients.

Current peer review mechanisms have been largely designed to identify physician outliers. These are physicians who demonstrate serious deficiencies in the care of patients as evidenced by review of inpatient medical records. Quality assurance capacities are now developing in an accelerated manner in ambulatory settings where the bulk of medical care occurs. Peer review in these settings will be designed to identify poor care and assure that physicians are consistently meeting expectations. The evolution of medical treatment requires continuing education.

A third impact of health care reform will be the increasing selectivity of physicians in choosing the CME that meets their individual needs. Self-directed learning, increasingly available in interactive software modules and through other innovative educational materials, may become the standard means of obtaining focused education. CME meetings will continue, but such meetings may be designed to facilitate increased interaction among physicians.

Finally the winds of reform may blow away at least part of the historical funding base of CME, namely industry support. While there is an appropriate role for commercial funding of CME programs and services, the medical profession may well decide that to regain the control of the practice of medicine, physicians must pay for their CME and not expect to be heavily subsidized by entities that have other agendas and promotional interests. CME will be viewed as a cost of practice and budgeted by groups and plans to assure that physicians are able to offer the high quality medical care to which they aspire.

Dr. Nelson is associate dean for continuing medical education at the University of Iowa College of Medicine.

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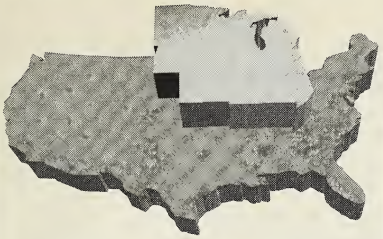
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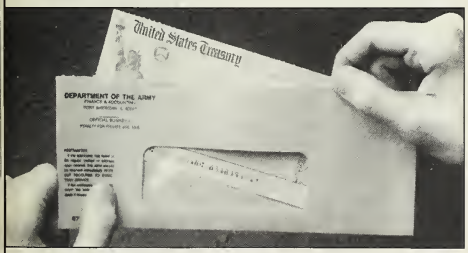
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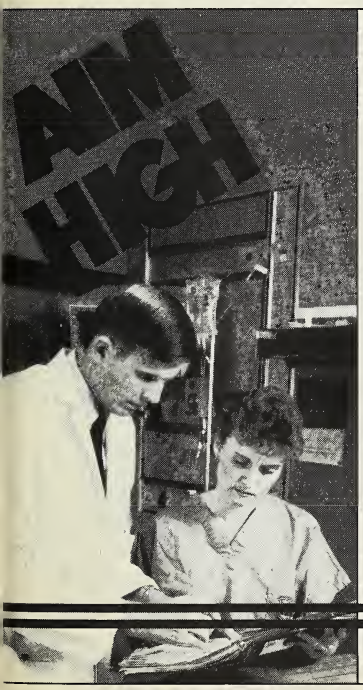
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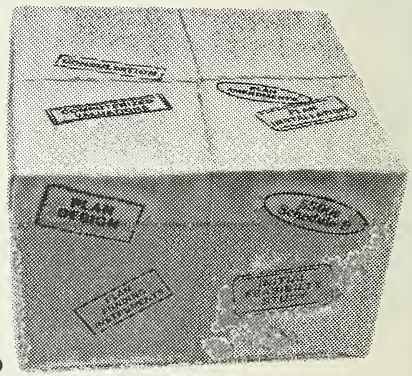
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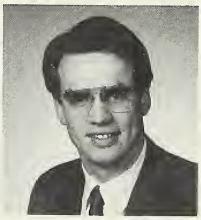
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